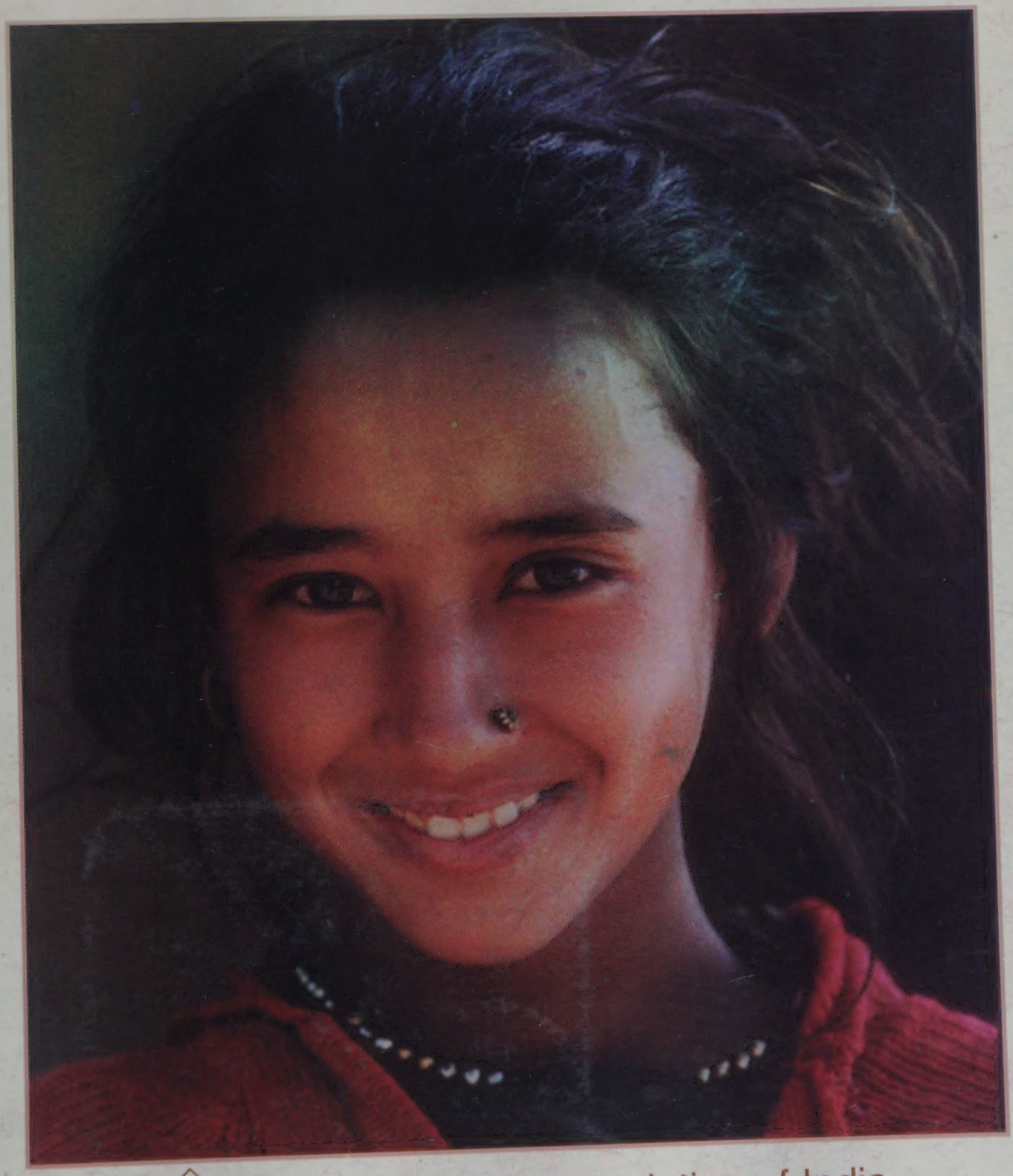
Darkness at Noon

Female Foeticide in India



Voluntary Health Association of India

DARKNESS AT NOON

Female Foeticide in India

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Summary of Project Report on
Declining Child Sex Ratio and Gender Balance
with special reference to Punjab, Haryana and Himachal Pradesh

By
. Voluntary Health Association of India
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Dedicated

to

all the unborn girls of

Punjab, Haryana and Himachal Pradesh

Contents

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Preface

As an expression of critical concern on the sharply declining child sex ratio in India, Voluntary Health Association of India (VHAI) initiated an in-depth investigation of the situation at the grassroots level. This was taken up in the three worst affected districts of Kangra, Fatehgarh Sahib and Kurukshetra in the States of Himachal Pradesh, Punjab and Haryana, respectively. The Project was financed by the Ministry of Health and Family Welfare, Government of India.

Since an investigation of a similar nature has not been taken up in the past, VHAI had to develop its own methodology. This effort was led by Professor Ashish Bose and Dr Mira Shiva as Principal Investigators, supported by an Advisory Committee. A group of field investigators with knowledge of the local socio-cultural and gender ethos was set up under the leadership of Shri Manmohan Sharma of Punjab Voluntary Health Association and Shri Rajan Mahajan of Himachal Pradesh Voluntary Health Association. The entire team was backed up by a Secretariat at VHAI ably run by Ms Anjali Garg. The professional statistical input was given by Ms Shrabanti Sen.

This monograph is the outcome of a rigorous field-level investigation, including collection of house-to-house data, interviews of interested groups backed by focus group discussions and perception surveys involving doctors, Panchayat members and married women.

The findings of the investigation are a sad commentary on the deteriorating gender situation in these three prosperous, educated and so-called 'forward-looking' States. The investigation also brings home the frightening tale of enthusiastic participation of the medical profession in this horrendous social malaise.

Addressing this malady would require action on many fronts, including strict enforcement of dowry law, creating more job opportunities for women, pension scheme for the elderly, stringent implementation of the Pre-natal Diagnostic Techniques (PNDT) Act and, of course, a general paradigm shift of social psyche among all sections of our population, which condone such gross discrimination against women.

We hope that the findings of this study will be useful for similar exercises in other parts of the country and will trigger appropriate action against this unbelievable downslide in the gender bias of our society.

As always, VHAI would go beyond this investigation to address this social malady not only in these three pockets, but all over India, networking with its 3500 member organizations.

15 August 2003

Alok Mukhopadhyay
Chief Executive

Introduction

The subject of this report is the rapid decline in child sex ratio and the causes and consequences of this phenomenon, based on analysis of primary data that we collected and secondary data obtained from the Census of India 2001. We have identified districts where the child sex ratio is abnormally low, indicating female foeticide. These districts are indeed the black holes in India's demographic transition and a slur on our civilisation.

During the past two decades, reproductive technologies in the form of amniocentesis, ultrasound and several other newer methods have enabled families to know the sex of the unborn child. The Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act was passed by Parliament in 1994 and was supposed to be operational from 1995 but nothing much happened till there was a public interest litigation (PIL) by concerned NGOs such as Centre for Health and Allied Themes (CEHAT). The Supreme Court did intervene in response to this PIL vide their order on 4 May 2001. Nevertheless, there was a mushrooming of unscrupulous doctors, quacks and abortionists, and most cities and big towns in India have facilities for prenatal diagnostic techniques. But what has Indian civil society done to take note of this perverse phenomenon?

Census of India 2001: shocking results

Let us start with the definition of sex ratio, which in Indian census usage denotes the number of females per 1000 males, while in western countries, it denotes the number of males per 1000 females. We shall use the term in the context of the Indian census to denote the number of females per 1000 males and the child sex ratio to denote the number of girls per 1000 boys in the age group 0–6 years. The definition of child varies but because of the data constraint (so far, the age data in the 2001 Census are available only for the age group 0–6 years), we shall use the term child sex ratio to mean the age group below six years. The overall sex ratio refers to the total population in all age groups. We shall give some highlights of the 2001 Census on child sex ratio:

- During the 1991–2001 decade, the overall sex ratio increased from 927 per 1000 to 933 per 1000 in India (an increase of 6 points).
- During the same period, the child sex ratio declined from 945 to 927 (a decline of 18 points).
- The sex ratio for the age group 7+ increased from 923 to 935 (an increase of 12 points).

While the increase in the overall sex ratio is a good development, the sharp decline in the child sex ratio is a disturbing phenomenon brought out by the Census data. How is it that in a decade, when the overall sex ratio has increased, the child sex ratio has declined sharply? This calls for serious analytical studies and, even more importantly, fieldwork to grasp grassroots realities. VHAI has attempted both these approaches in this study on female foeticide with special reference to Punjab, Haryana and Himachal Pradesh (HP). In this summary report we will present only some important findings.

A detailed look at the child sex ratio for the past four decades shows that it has been declining continuously and the decline has been the sharpest from 1981 onwards (Table 1).

We then move on to the States. Table 2(a) indicates States where the decline is most pronounced. Table 2(b) shows the States where the decline is marginal or there is even an increase in the child sex ratio.

It will be noted that the States listed in Table 2(a) are the most prosperous States in India. Why has social backwardness overtaken their economic development? Regarding the States listed in Table 2(b) one may ask why have these States not become victims of the social malaise reflected in the declining child sex ratio?

We then go for district-level analysis. The districts with the lowest child ratios may be classified into three categories as follows:

D1: child sex ratio 850–900
D2: child sex ratio 800–850
D3: child sex ratio 750–800

Obviously the worst category is D3.
All the States and districts in India can be classified according to the level of child sex ratio. Our acronym to indicate the worst districts is 'DEMARU': **daughter eliminating male aspiring rage for ultrasound**. We have rated all the districts in the three worst States, namely Punjab, Haryana and Himachal Pradesh

Table 1. Child sex ratio, 1961–2001

Year	Sex ratio (0–6)	Variation (points)
1961	976	
1971	964	–12
1981	962	–2
1991	945	–17
2001	927	–18

Table 2(a). Decline in child (0–6 years) sex ratio

State/UT	1991	2001	Variation (points)
Punjab	875	793	–82
Haryana	879	820	–59
Himachal Pradesh	951	897	–54
Chandigarh	899	845	–54
Gujarat	928	878	–50
Delhi	915	865	–50
Uttaranchal	948	906	–42
Goa	964	933	–31
Maharashtra	946	917	–29

Table 2(b). Marginal decline or even increase in child sex ratio

State/UT	1991	2001	Variation (points)
Pondicherry	963	958	–5
West Bengal	967	963	–4
Mizoram	969	971	+2
Kerala	958	963	+5
Sikkim	965	986	+21

Table 3. Demographic black holes: DEMARU States and districts
(The child sex ratio in 2001 is given in brackets)

1. **PUNJAB: Overall rating—D3 (793)**
   Districts:
   D1: nil
   D2: Faridkot (805), Muktsar (807), Nawanshahr (810), Hoshiarpur (810), Ludhiana (814), Ferozepur (819), Moga (819)
   D3: Fatehgarh Sahib (754), Patiala (770), Gurdaspur (775), Kapurthala (775), Mansa (779), Bhatinda (779), Amritsar (783), Sangrur (784), Roopnagar (791), Jalandhar (797). *Note: All the 17 districts are in the D category.*

2. **HARYANA: Overall rating—D2 (820)**
   Districts:
   D1: Faridabad (856), Gurgaon (863)
   D2: Jhajjar (805), Panipat (807), Karnal (808), Yamuna Nagar (807), Rewari (814), Mahendragarh (814), Jind (818), Sirsa (818), Hissar (830), Fatehbad (830), Panchkula (837), Bhiwani (838)
   D3: Kurukshetra (770), Sonepat (783), Rohtak (796), Ambala (784), Kaithal (789).
   Note: All the 19 districts are in the D category.

3. HIMACHAL: Overall rating—D1 (897)
   Districts:
   D1: Hamirpur (864), Bilaspur (884), Solan (900)
   D2: Kangra (836), Una (839)
   Note: 5 out of the 12 districts belong to the D category.

Space does not permit us to give details for all the States in India. In Appendix table 1 we have listed the 50 worst category districts in India covering 11 States and Union Territories (UTs).

Table 3 indicates that Fatehgarh Sahib in Punjab, Kurukshetra in Haryana and Kangra in Himachal Pradesh are the worst districts. VHAI decided to take up intensive fieldwork in these districts to find out what was happening at the grassroots level. Our hypothesis was that if we could tackle the worst districts we could certainly improve things in other districts with suitable intervention strategies. VHA Punjab and VHA Himachal Pradesh joined us in undertaking our difficult fieldwork, which by virtue of the secrecy and sensitivity of the issue under consideration called for tremendous tact and skills in survey methodology and data collection. It goes to the credit of our field staff that we could succeed in collecting reliable data. Apart from our perception surveys of doctors and Panchayat members and interviews of married women, we had the benefit of a series of focus group discussions and interactions with village people, which gave us valuable insights into this complex social phenomenon we were investigating.

In the following pages we shall give some highlights of our findings but before doing so, we shall discuss the implications of emerging medical technologies and the legal ramifications of the PNDT Act.

Chapter 2

Methodology of our Study

While there have been several statistical studies on the phenomenon of declining child sex ratio, there are very few field studies on the subject. We had to devise our own methodology and questionnaires, which we pre-tested before launching the survey.

Our focus was more on perception than on demographic analysis. There have been surveys such as the National Family Health Survey (NFHS-1 and -2), which have collected massive data on the basis of large samples. Reports are available for all the three States under study. The Census also gives enormous data on the demographic, economic and social conditions of the people of the State at district, tehsil and individual city and village level (depending on the tabulation scheme), but in the Census there are no questions on perception and, obviously, a government agency cannot collect data on an activity that is illegal (namely, widespread use of ultrasound to detect the sex of the unborn child). We conducted the following perception surveys:

1. Perception survey of doctors (both men and women and government doctors as well as private doctors)
2. Perception survey of Panchayat members (men and women members of Panchayats).
3. Perception survey of married women in each household in the 9 villages selected for intensive study. This perception survey was an adjunct to the household survey done on a 100% basis (i.e. it was not a sample survey and the entire village was covered).

Apart from these rounds of perception surveys, we conducted a series of focus group discussions (FGDs) in all the three States under study with the help of State Voluntary Health Associations and other organisations such as the Chinmaya Tapovan Trust, and Sidhbari, Himachal Pradesh.

Finally, we took full note of a series of interactive workshops organised by VHA of Punjab at Chandigarh and in several villages, involving a large number of government health functionaries, doctors, auxiliary nurse midwives (ANMs), dais and other health workers of NGOs working at the grassroots level. We also took note of several other workshops involving doctors, lawyers, prominent citizens, health activists and women's organisations which deliberated on the subject of female foeticide.

Apart from these field surveys, we decided to study the perception of the print media by scanning news items, articles and editorials in leading newspapers and we have provided some highlights of the media's response to this emerging social malaise. We have also briefly referred to recent studies of demographers on the subject of female foeticide.

Our starting point was a quick analysis of the 2001 Census data on the overall sex ratio as well as the child sex ratio. Demographers were

the first to comment in the press, on radio and television, and also in magazines and journals on the issue of female foeticide.

We have also briefly discussed some medical aspects of emerging technologies that have enabled the widespread use of sex determination tests. This is followed by a study of the PNDT Act with recent amendments, the MTP Act, etc., and the government's efforts to curb female foeticide through legislation.

Our methodology has the following main elements:

1. Quick analysis of the first results of the 2001 Census of India;
2. Launching field surveys in selected States, districts and villages. Selection of three contiguous States namely, Punjab, Haryana and Himachal Pradesh which have the worst scenario judged by the 2001 Census data on child sex ratio;
3. Selection of the 3 worst districts in these 3 States, again based on the 2001 Census data. These districts were Fatehgarh Sahib in Punjab, Kurukshetra in Haryana and Kangra in Himachal Pradesh.
4. In these 3 districts, we selected 3 villages each on the basis of the tehsil data on child sex ratio and proximity to the main road. We selected one village which was near the road, one village which was very remote, and one village which was in between. Our intensive study was based on a 100% house-to-house survey in these 9 villages;
5. Analysis of emerging medical technologies and the legislation to curb female foeticide and its implications;
6. Analysis of print media coverage and the response of the media to this growing social malaise.

Table 1. Details of fieldwork

State/District	Number of households surveyed in villages	Number of married women interviewed
Haryana (Kurukshetra)	566	489
Punjab (Fatehgarh Sahib)	617	292
Himachal Pradesh (Kangra)	218	218
TOTAL	1401	999

Total number of doctors and panchayat members interviewed

State/District	Doctors	Panchayat members
Punjab (Fatehgarh Sahib)	19	26
Himachal Pradesh (Kangra)	53	20
Haryana (Kurukshetra)	Nil	18
TOTAL	72	64

Chapter 3

Misuse of Medical Technology

Technology is not neutral in value. It can be used to serve society and it can also be used to perpetuate biases, exploit society and even help in its extermination.

The misuse of medical technology for sex determination and female foeticide is one such example. In a social context, where there are deep-rooted biases against a girl child, gender discrimination becomes a deeper 'male fixation'. Any technology that prevents the birth of a girl child finds a big market. Similarly, technology that claims to promote the birth of a boy child would find an even greater market.

Availability and affordability of technologies for prenatal sex determination have played a very major role in the masculinisation of the sex ratio in India.

In 1971, ICMR conducted a study on amniocentesis to evaluate its potential for sex determination. Some seriously wanted to promote it as a mode of population control. Following protests by women's groups, a partial ban was brought about in 1976.

Amniocentesis as a technology was first used outside India in 1937 and for sex determination in 1951. The first private clinic in India was established in Amritsar in 1979 and the practice spread rapidly over Haryana and Punjab. Hoardings and advertisements came up. Following the anti-amniocentesis campaign launched in 1982 by women's groups and health groups for effective control on the functioning of amniocentesis centres, there was a steady take-over by another medical technology—ultrasound. This technology was

- non-invasive
- easily accessible
- affordable for the client as well as the service provider
- had legitimate uses and therefore provided a safe cover.

As population control required fewer children and families demanded male progeny, women turned increasingly to this technology for help. Medical doctors found this an easy means of income generation. Some even truly believed that they were helping women to escape oppression and also helping the national population control programme.

Ultrasound uses the principles of sonography for examination of various organs of the body and is used as a diagnostic tool for pregnant as well as non-pregnant women, men and children. Sex determination is done by visualizing the genitalia of the unborn baby in the womb of the mother. This is possible from 14 weeks onwards though some unscrupulous people doing these tests claim to do so at 10 weeks, which is not possible. It may be noted that repeated use of ultrasound in pregnancy is harmful as high frequency waves may adversely affect the human tissue during formation and therefore function.

Ultrasonography involves sex determination mainly in the second trimester followed by female foeticide (also called 'sex-selective abortion'). Because of the late stage, this results in a greater health hazard for the mother as the second-trimester and delayed abortions are associated with a higher mortality and contribute to the unacceptably high maternal mortality rate. It is estimated that in India there are over one lakh ultrasound machines.

Pre-conception sex selection

While technologies involving sex determination of the foetus are associated with female foeticide, technologies making sex pre-selection possible at the preconceptual stage avoid abortion (besides being unethical, these have safety and cost concerns). Ericsson's method has been popularised in certain parts of India, for example, in Punjab, many such clinics have come up. Serious concerns about the accuracy of such tests have been expressed by the experts of a Technical Supervisory Board set up by the government.

In vitro fertilisation (IVF) is used for infertile couples. This technique causes superovulation through drugs such as clomiphene, followed by fertilisation with the sperm of the partner outside the womb. The multiple fertilised ova are then implanted in the womb. Babies thus born are often called 'test-tube babies'. Bias towards the male child is obvious in IVF clinics.

Human cloning

With a deep-rooted patriarchal thinking, as also a patriarchal functioning of the medical–legal–religious systems, it will not be surprising that in future if there is a preponderance of male babies in mother India when and if human cloning does take place.

First and foremost, there is an urgent need to address the fundamental problem of changing the patriarchal mindset. Only then will regulation of technologies work. Unless the pathology of the mind changes, the pathological use of medical technologies will continue.

Chapter 4

Legal Implications

The issue of pre-birth determination and female foeticide was initially an ethical issue. The trivialisation of abortion, the medicalisation of sex determination and female foeticide resulted in numbing the sense of wrongness. Promotion of abortion as a substitute for family planning, where the majority of abortions were conducted for 'contraceptive failure' even at 20 weeks, was possible only because of the 'Family Planning and Population Control' mindset of medical practitioners.

The first partial legal ban on amniocentesis came in 1976. There were massive protests by women's groups—Jagori, Saheli, Action India, JWG (a forum against sex determination) and health groups such as MFC and VHAI in the 1980s. In 1988, the Maharashtra Act was enacted. In 1991, the Prevention of Pre-natal Diagnostic Tests (Prevention of Misuse and Regulation) Bill was presented in Parliament.

Parliamentary hearings were held. Women's groups made a plea:

- not to victimise the victim;
- cover ultrasound (which was not included in the Bill);
- cover any other medical technology capable of sex determination including sex pre-selection.

In 1994, the PNDT Act was passed. In 1996, the Act came into force with the rules framed under the Act. The Act resulted in the disappearance of hoardings and advertisements for sex determination. Unfortunately, sex determination tests have continued and, in fact, spread more rapidly even to remote areas with the advent of ultrasound. In 2000, CEHAT, MASUM and Sabu George filed a Public Interest Litigation (PIL) in the Supreme Court for non-enforcement of the Act. The 2001 Census figures shocked the nation by reporting a sharp decline in the child sex ratio (0–6) in the past decade. This was the most striking in Punjab, Haryana, Delhi, Himachal Pradesh, Chandigarh, Gujarat and parts of Maharashtra.

The Supreme Court, taking cognizance of the situation and the prayers of the petitioners, ordered strict enforcement of the Act by

- registration of all ultrasound centres, machines including mobile medicines;
- registration of clinics, centres, counselling centres with ultrasound machines;
- registration of the doctors owning and using the machines (including part-time doctors);
- putting up of boards proclaiming that sex determination tests were not done;
- asking ultrasound manufacturers to submit a list of purchasers of ultrasound machines.

The Central Supervisory Board, which had not met, was asked to take the issue more seriously. A Technical Committee was formed to look for lacunae in the PNDT Act to introduce Amendments to the Act. Another Technical Committee was formed to ensure the Implementation of the Act. The PNDT Amendment Act was passed in 2002. Under the 2002 PNDT Amendment Act, the title of

the Act has been changed to 'The Pre-conception and Pre-natal Diagnostic Technique (Prohibition of Sex Selection) Act'. The amended rules came into effect from 14 February 2003.

To ensure better implementation of the Act, State-level Supervisory Boards are to be formed. Their constitution, powers and responsibilities have been clearly defined. This is besides the Central Supervisory Board, and the Central, State and District Appropriate Authority.

The punishment for violation of the Act has been increased. A list of indicators, i.e. conditions for which ultrasonography can be done, especially in pregnancy, are clearly defined. Information on who can make a complaint and how to do it has been given. Realising that most Appropriate Authorities are medical professionals and not too familiar with laws and their implementation, a Handbook on PNDT Act 1994 and its Amendments has been brought out by the Ministry of Health and Family Welfare. Workshops, seminars, training programmes have been held, and posters, spots, booklets have been brought out.

Unfortunately, sex determination and female foeticide (SDFF) continues unabated. In fact, it seems to be increasing. This is because the pressures on women to give birth to a male child have increased, the harassment after a girl child is born has increased, dowry demands and dowry harassment have increased, increasing insecurity for and violence against women. Sex determination and female foeticide is just the tip of the iceberg. Moreover, due to the legitimate use of ultrasound in pregnancy, allegedly for assessing the 'viability of the foetus', ultrasound use in the second and third trimesters of pregnancy continues. With only the client and provider involved, it is very difficult to obtain implicating evidence for taking any legal action.

With the provision that any pregnant woman going for sex determination amounts to violation of the Act, it is very unlikely that women would complain even if forced to undergo ultrasonography. The situation is similar to that caused by the Prevention of Immoral Traffic Act, when it is usually the commercial sex workers (CSWs) who are caught and punished. So far, some action has been taken against whatever violation of the PNDT Act has been reported. These refer to violation of the procedural details, e.g. non-registration, non-maintenance of records, etc.

The question remains: Will the chances of baby girls being allowed to be born improve with the effective implementation of the PNDT Act? Will the mother of the baby girl be treated the same way as the mother of the baby boy by the in-laws, family and society? Will women be accepted only as the *bibi, bahu, beti* of some men and not as themselves; as valued human beings whose contribution to the family, workplace and society is constantly discounted? Legal action can work only when gender justice is ingrained in society.

The virtual non-implementation of the Prohibition of Dowry Act, even when the killers are named by the victims in the dying declaration, raises fundamental questions about gender issues. The increasing number of abductions of baby boys from hospitals, and repeated SDFF at the cost of the mother's health shows the desperation to have sons and not daughters.

Chapter 5

Highlights of the Perception Surveys

In the following pages, we briefly present the highlights of our surveys.

I. Doctors' Perception Survey

Our survey covered 53 doctors in the Kangra district of Himachal Pradesh who were interviewed with the help of a questionnaire. While selecting the respondents, care was taken to include doctors from both the sexes in different age groups, practising in government organisations, and the public and private sectors. We did a pilot study in Chandigarh and Punjab. The following tables present the respondents' profile.

Highlights of The Doctors' Perception Survey

1. Perception questions

- When the doctors were asked about the main health problems in the district, *58% felt that anaemia was a major health problem.* Tuberculosis (36%), waterborne diseases (26%) and malnutrition (23%) were stated as other major health problems.
- Realising the connection between anaemia and the reproductive health of women, we tried to assess the incidence of anaemia among women. As many as 43% in Himachal Pradesh *replied that it was prevalent to a moderate extent among women,* followed by *38%* who felt it was *severe.*
- 49% of respondents expressed their ignorance about the contribution of anaemia to maternal mortality.

2. PNDT Act: Knowledge, awareness and perception about the PNDT Act and views on the implementation of the Act

- When the respondents were asked if they were aware of the PNDT Act, 90% *replied in the affirmative and the rest in negative.*
- *89% of the doctors felt that the Act could be implemented.* On exploring further, it was found that in *the opinion of a majority* (59%) *of doctors of Himachal Pradesh, women were mainly responsible for the sex determination test, thus suggesting that women be punished under the PNDT Act.*
- All the respondents (100%) stated that both sex determination and female foeticide were illegal and unethical practices. For effective implementation, 45% of respondents expressed the need for modifications in the Act.

3. Discussion on the practice of ultrasound tests during pregnancy

- According to 43% *of the doctors, the sex of the foetus could be determined before 12 weeks,* showing a surprising lack of awareness, as the sex of the foetus cannot be determined before 12 weeks of pregnancy.
- When the respondents were asked if ultrasound machines should be banned, a majority of doctors (90%) said that it should **not be banned,** though over 95% *of doctors strongly felt that the ultrasound machines were being misused for sex determination* in their respective regions.
- Doctors' views were sought on the impact of the Family Planning Programme (FPP) with its 2-child norm on female foeticide. *The responses indicate that over* 50% of the doctors thought it did lead to female foeticide.

Highlights...

4. Response to sex determination test

- Posing a direct question to the respondents, asking if they were involved in conducting abortions would have offended them leading to a simple 'No'. To get near to the reality, the question posed was: 'Are you aware of doctors who refer women to ultrasound centres? If yes, how much commission do they get from these ultrasound centres?'
- The response revealed that the majority of doctors (53%) accepted the fact that there were some doctors in the district referring pregnant women to ultrasound centres for sex determination tests; 34% responded in the negative and the rest (13%) preferred not to respond.
- 85% of the doctors expressed their ignorance about the commission doctors get by referring pregnant women to ultrasound clinics; 9% felt it depended on the clinics and doctors, and 6% felt the commission was very high.

5. Sex of the unborn child while conducting abortion

- We asked the doctors if they were aware of the sex of the child while conducting abortions; 66% doctors did not respond. However, the remaining 34% stated that the doctors were aware of the sex of the foetus while conducting abortions.

6. Awareness regarding use of the MTP and the MTP Act

- All (100%) the doctors were familiar with the MTP Act, 1971. Only 34% of the doctors accepted that they were conducting abortions.
- Regarding the various methods used for conducting abortions, 75% stated that modern methods were being used. 70% mentioned the D&C method, 59% supported S&E and 19% emcredle.

7. Female foeticide (FF): Who is responsible?

With regard to sex-selective abortions and female foeticide, where doctors are considered the main culprits, we tried to seek the doctors' viewpoint by posing the question, 'Do you think doctors are sometimes pressurised by families and pregnant women for SDFF?'

- More than half (58%) stated that *doctors were pressurised to conduct SDFF;* 21%, *however, did not think so.*
- The respondents were asked who was to be held responsible for pregnant women going in for SDFF; 64% said that it was the woman herself, 72% held the husband responsible, 70% felt that it was the in-laws, 53% blamed the community and 17% felt that it was others.

8. Punishment for conducting sex-selective abortions

- According to 50% of the doctors, pregnant women opting for sex-selective abortion should be punished. Among other responsible persons who must be punished were doctors (74%) and the in-laws (62%).

9. Steps for curbing female foeticide

- All doctors unanimously opined that there was a need for an *attitudinal change towards the girl child, with an increase in educational and awareness programmes. Also, the media needs to play a more proactive role in enhancing community participation.*

10. Suggestions to curb female foeticide

- 56% of the doctors suggested that interventions should be made at the medical level and 66% suggested that the Indian Medical Association (IMA) and other forums should discourage the practice of female foeticide by better education. Of the doctors 66% opined that intervention

must be made at the family and community level, with a focus on women's empowerment.

- Although all (100%) doctors were of the opinion that pre-natal sex determination tests were illegal and unethical practices, 95% accepted that *ultrasound machines were being misused for sex determination.*
- Although 100% doctors claimed familiarity with the PNDT Act, none of them were aware of the details of the Act as they could not state the punishments for various defaulters under the Act. *In order to make the law functional, greater awareness is needed regarding the law (against this crime) as doctors should know the grave consequences of getting caught.*
- According to 50% of the doctors, pregnant women opting for sex-selective abortion should be punished for the act. This reflects *the narrow understanding on the part of some doctors in our patriarchal culture.*

Where does then one begin?

The respondents themselves provided the answer. The majority (56%) said that the various medical forums such as the Indian Medical Association (IMA), Indian Academy of Paediatrics (IAP), Federation of Obstetrics and Gynaecological Society of India (FOGSI) should discourage the practice.

II. Perception Survey of the Panchayat Members

The following section presents some highlights:

1. Empowerment of Women

1.1. Political: Impact of one-third Reservation for women in the Panchayat system

- The women Panchayat members had a mixed opinion. In view of 5 members in both Haryana and Punjab and 7 in Himachal Pradesh the scheme has not led to women's empowerment. At the same time, 7 in Haryana and 8 in Punjab felt that the one-third reservation quota for women had not empowered women.

It was evident that *women get a chance to step forward and gain the people's respect in 'mahila mandals'.*

1.2. Educational: Status of girls' education in the village; reasons for girls not going to school

- **Educational level:** In the villages surveyed, girls are sent to school, at least till the 10+2 level.

1.3. Economic: Status of government policies and programmes for women (income generation and skills training)

- A majority of Panchayat members reported that they did not have any programme or scheme in their village for women's empowerment.
- For both income generation and skills development, there were Sewing Centres as informed by both male and female Panchayat members.
- Regarding the employment status of women in the village, a negligible number of women were working outside their homes in sectors other than agriculture.

1.4. Expectations from the government for women's empowerment

- For the overall development of the village and its people, all (100%) Panchayat members felt that more empowerment opportunities should be provided for the villager through the setting up of industries in the village.
- By asking specifically about the desired intervention by the government for women's empowerment, it was found that

a majority of the Panchayat members (5 women and 7 men) strongly felt that more *employment opportunities* should be provided for women by the *setting up of small-scale industries.*

2. Marriage and Dowry

2.1. Marriage decision: Although the question was open-ended, both male and women Panchayat members unanimously opined that *marriage matters were mainly decided by the parents.*

2.2. Type of marriage: The previous question itself answered the type of marriage being accepted in the villages. All (100%) Panchayat members (both male and female) did not *approve of love marriages, inter-caste or inter-religion marriages.*

2.3. Criteria for looking for the bridegroom: The main criteria considered by all the Panchayat members are caste, religion, income, land ownership and education.

2.4. Discernment about the cost of marriage: The cost of marriage is very high, above Rs 1,00,000. The members felt that ***there was no limit.***

Some of the reasons mentioned by the Panchayat members for a formidable increase in the 'cost of marriage' were: to show off; to enhance 'social status'; and to ensure the 'security' of the girl in her in-laws' home.•

2.5. Perception about unmarried youth in the village due to fewer numbers of girls: All (100%) Panchayat members deemed that these boys must be married off as *unmarried youth have a comparatively low status in the society.* Panchayat members further expressed that if these youth remained unmarried, *it might increase violence against women in the society.*

The various factors responsible for such criminal activities of unmarried youth as perceived by the Panchayat members would be to fulfil their desires; no social bond; and lack of responsibility.

2.6. Child Marriage: Child marriage is not practised in any of the villages we studied.

2.7. Approval for widow remarriage: *All (100%) respondents in Haryana expressed their approval of it.* This general acceptance for widow remarriage in Haryana is due to the fact that this custom popularly known as *Karewa, karao* or *chaddar andazi* has been a feature common with both lower and upper caste groups in villages in Haryana. The widow either gets married within the deceased husband's household or to some other member of the same community.

❖ Unlike Haryana, in *Punjab all (100%) respondents expressed their disapproval of it.* In Himachal Pradesh, 80% expressed acceptance for widow remarriage.

2.8. Prevalence of dowry: According to all (100%) panchayat members, the dowry system is spreading in their respective villages.

3. Perception, Knowledge, Attitude Towards Female Foeticide

3.1. Awareness about female foeticide: Though there is a substantial decline in the female male sex ratio in all the three

districts, the denial by a majority—10 Panchayat members (6 women and 4 men) or ignorance by 4 members (3 men and 1 woman) in Haryana and all (100%) in Punjab and by 45% Panchayat members (6 men and 3 women) in Himachal Pradesh—about the occurrence of female foeticide in their villages leads us to think that the Panchayat members were afraid to state facts regarding female foeticide because of the Supreme Court's proactive stand on the implementation of the PNDT Act.

3.2. Cost of ultrasound: Of the Panchayat members, only 3 women and 2 men in Haryana stated that the cost of an ultrasound test varied between Rs 150 and Rs 750. In Himachal Pradesh, 16 Panchayat members said that the cost of an ultrasound test was between Rs 500 and Rs 1000.

3.3. Communities practising female foeticide in the village: All panchayat members in Himachal Pradesh felt that female foeticide was practised equally in all the communities.

3.4. Reasons for practising female foeticide: All panchayat members blamed the family for the occurrence of female foeticide.

- All the respondents alleged that the New Population Policy 2000, *allowing only those with two children to become Panchayat members, has invariably increased female foeticide in the villages.*

3.5. Gender violence: The majority of Panchayat members told us that women face different types of *violence such as eve-teasing, more agricultural work pressure on women, domestic violence, etc.*

3.6. Understanding about the number of girls in the village: According to an overwhelming majority, the *number of girls in their villages was decreasing.*

3.7. Dependence of the status of mother on the birth of a 'son': All panchayat members accepted the fact that the *status of mother increased only with the birth of a male child.*

III. Household Opinion Survey

(Canvassed from married women)

The study universe comprised all (100%) households in the three selected villages of each district of the three States, i.e. Punjab, Haryana and Himachal Pradesh. In all the three villages of each of the three districts from the respective States, a complete house-to-house survey was done and a woman in each household was asked a number of open-ended questions. Village-wise distribution of the sample in Punjab and Haryana is shown in Table 1.

Table 1. Village-wise distribution of the sample in Punjab and Haryana

	Village	Number of respondents
Punjab	V-1	211
	V-2	223
	V-3	183
	TOTAL	617
Haryana	V-1	246
	V-2	152
	V-3	168
	TOTAL	566
GRAND TOTAL		1183

Highlights of findings of the Household Opinion Survey

1. Reasons for the preferred progeny (son/daughter)

- When asked if they considered girls to be a burden, *88% of respondents in the* V-1*; 71% in* V-2 *and 74% in* V-3 *villages* of Punjab *and 83% of respondents in* V-3 *village, 58% in* V-2 *village and 88% in* V-1 *village of* Haryana *did not consider girls burdensome.*
- The majority of respondents, in both the States (100% in V-1; 95% in V-3 and 91% in V-2 in Punjab) *considered dowry as a major factor responsible for the deteriorating condition of women.*

How dowry is lowering the existing status of women in our society can be judged by the following responses:

- ***'With increasing cost of living, dowry is also increasing.'***
- ***'Even if the girl's parents are poor, they have to give dowry to get the girl married.'***
- ***'. . . necessary to give dowry to make their daughter happy and respectable in the in-laws' family.'***
- ***'. . . given as a mark of respect of self and in-laws.'***

Reasons for son preference

When the respondents were asked whether they considered a son to be a blessing and the daughter a burden, the following reasons were given for considering 'a son to be the preferred choice': *to run the family name; make the family and parents respectable in the society; for social and economic support; to inherit the family property; and take care of parents in their old age.*

2. Practice of prenatal sex determination

2.1. Decision to go in for a sex determination test: In Haryana, 74% in V-3, 73% in V-2 and 74% in V-1 mentioned the woman's husband to be responsible, and 65% in V-3, 39% in V-2 and 65% in V-1 considered the women responsible. In Punjab, 100% in V-1, 56% in V-2 and 93% in V-3 considered the woman's husband to be responsible, and 92% in V-1, 87% in V-2 and 93% in V-3 held pregnant woman to be the decision-maker.

3. Supporting abortion due to financial reasons

To get a better insight of the various push factors compelling families to go in for sex-selective abortion, the varied responses to our open-ended query has led to important findings. Nearby half, i.e. 45% *respondents* in V-1 and 26% in V-2 village in Punjab and 95% *respondents* in V-3 village of Haryana expressed their support for abortion due to various financial reasons. *In case of a girl child, dowry is an additional expenditure; with the increasing cost of living, it is difficult to manage a large family.*

4. Awareness about the practice of sex determination test and female foeticide

To get an understanding about the occurrence of SDFF in the respective villages, an indirect question was posed, 'Who conducts abortions in your area?' The responses, holding mainly the doctors responsible for conducting abortions, confirmed the prevalence of the practice of SDFF in all the three villages with the *involvement of the medical practitioners. The role of quacks, ANMs and dais was negligible in all the three villages.*

5. Cost of ultrasound test and abortion

- Of those who spoke about the prevailing cost of ultrasound and abortion in Punjab, in V-1 village, 63% said that it was within the range of Rs 500–1000 and the rest categorised it within Rs 1000–1500. In V-3 village, 39% of the total respondents said that the cost ranged Rs 500–1000 and 26% put it within Rs 1000–1500. In the third village, i.e. V-3, the response of 21% respondents about the cost of these tests ranged Rs 500–1000 (6%); Rs 1000–1500 (10%); and Rs 1500–2000 (5%).
- In Haryana, 54% in V-3, 28% in V-2 and 41% in V-1 stated that it was below Rs 500. The range was Rs 2500–3000 according to 23% respondents in V-3 village, 25% in V-2 and 45% in V-1 village.

6. Awareness about the law on prenatal sex determination test and source of information

- Though the practice of SDFF is rampant in the village, it was shocking to realise that *100% of respondents in all the three villages of Haryana and 97% in V-1 and 43% in V-2 village of Punjab were* not aware of the legal provisions *against the practice of prenatal sex determination and foeticide, i.e. the PNDT Act, 1994.*
- On the contrary, in V-2 village of Punjab, 93% were aware of the law against the practice of prenatal sex determination and their main source of information was the television and newspapers.

7. Effects on society

We tried to assess people's perceptions about the repercussions of this continuous decline in the female-to-male child sex ratio. The likely ill-effects were increase in atrocities on women; social imbalance with a decline in moral values; polyandry; purchasing brides from other States thus affecting the State's culture; more men remaining unmarried. Despite realising the dire consequences ranging from an increase in crime against women to difficulty in getting boys married and major social imbalances, it is very clear that the *practice of SDFF is continuing and 'dowry' is one of the important factors perpetuating it.*

Discussion

The data along with its analysis presented earlier give some interesting indications and throw light on several very important issues that need to be addressed in order to tackle the problem in a more effective manner.

- Findings of the study confirm that a majority of the people in all the villages in Punjab and Haryana considered *doctors to be mainly responsible for conducting abortions.*
- The findings further indicated various reasons for the sharp decline in the female-to-male sex ratio. The immediate cause for the practice of female foeticide is that daughters are perceived as an economic and social burden on the family due to several factors such as dowry, the danger to her chastity and the worry about getting her married. A majority of respondents in all the villages of the two States considered dowry to be a major factor responsible for the deteriorating condition of women.
- Female foeticide is also dependent on the facilities available, such as ultrasound and genetic tests. In both Punjab and Haryana, the easy and abundant availability of these facilities prompts the people to avail them.
- As mentioned before, awareness regarding the law was found to be very poor among the masses. This underscores the need to make the general public aware of the various important provisions under the Act. ***The ultimate solution lies in the fundamental restructuring of our society on the foundation of gender equality and justice.***

Need for Societal Action: Critical Issues

President K.R. Narayanan, in his Republic Day address in 2002, referred specifically to female foeticide in the context of the 'deplorable status' of women. He also referred to the increasing incidence of rape, domestic violence, sexual harassment at workplaces and trafficking of women. In the powerful words of the President, 'the crime statistics are indicative of women's traumatised existence. No place is safe for them, not even in their mother's wombs. They are put to death before they are born.'

There are ethical aspects of the misuse of ultrasound machines. To quote Dr M.C. Kapilashrami, Director of the National Institute of Health and Family Welfare: 'As foetal sex determination by ultrasound is not possible in the first trimester, this is a false and exploitative practice taking advantage of the ignorance of the population. In order to curb this, it is essential that as part of the IEC activities connected with the PNDT Act, an awareness generation campaign is taken up informing the public that it is not possible to determine the foetal sex by ultrasonography in the first three months of pregnancy' (*NIHFW Newsletter,* October–December 2001).

Are our girls doomed? Are we heading towards distorted, perverted, daughterless families as the epitome of Indian society?

Curbing foeticide

The term 'sex-selective abortion' is in use in recent years and United Nations publications also use this expression. But if our objective is to fight foeticide we must know how best to convey the message of condemning foeticide to the masses. From this point of view, we would recommend the term 'female foeticide' instead of 'sex-selective abortion'. In Hindi, foeticide is translated as *'bhrun hatya'* and this term communicates the gravity of the problem; the term foeticide, akin to genocide, invokes a sense of guilt, anger and passion. It is a glaring case of social injustice. In this context, reference may be made to the Medical Termination of Pregnancy (MTP) Act, 1972. All over the country, abortion is known as MTP. If we start using the term sex-selective abortion, we will be conveying nothing to the masses. Our lawmakers were tactful in referring to abortion as medical termination of pregnancy because traditional Indians still look down upon abortion as immoral, unethical and irreligious. But when one talks of MTP, the entire subject is put in the arena of medical doctors. In the people's perception it is the doctor who has to decide whether the abortion should take place or not and whether it poses a danger to the life of the mother and/or the child. In short, a moral controversy has been tactfully transformed into a medical issue. That is why there is hardly any opposition, whereas in several western countries there is an intense controversy on the issue of abortion, which even has political overtones. Without arguing further, we recommend the use of the term 'female foeticide' to arouse the conscience of the people to fight a growing social malaise.

Unholy alliance of tradition and technology

During the past two decades there has been a growing alliance between tradition and technology: tradition reflected in the 'son complex' and technology reflected in amniocentesis (which was later replaced by ultrasonography). Both the 1991 and 2001 Censuses recorded a sharp decline in the child sex ratio and, as already noted, during the past decade the decline was even sharper. Of all the explanations offered for the decline in the child sex ratio (0–6 years), the most convincing one is attributed to female foeticide. Here it is important to note that the PNDT Act was passed in 1994 and, as our study shows, amniocentesis as the favoured technology was replaced by ultrasound, thanks to the loopholes in the PNDT Act. It is also worth noting that amniocentesis was a costly technology, whereas ultrasound is much less expensive and much more common in medical use. It cannot be banned because it is an essential tool for monitoring pregnancies as well as for detecting disease. The Supreme Court has in recent years played a commendable activist's role, taken note the PILs of concerned NGOs and asked the Government of India and the States (through the Health and Family Welfare Secretaries) to explain why the PNDT Act was not being effectively implemented.

Our fieldwork shows that the inherent and deep-rooted 'son complex' in Indian society has been triggered by medical technology, which enables detection of the sex of the unborn child, and also by improvements in the technology of conducting abortions. It is doubtful if the legal machinery alone can counteract this triggering effect. We feel that in the confrontation between doctors and lawyers, doctors will get away because lawyers are unlikely to succeed in producing evidence in the court that some doctor had misused ultrasound. In view of the PNDT Act, no doctor indulging in sex determination tests will record anything on paper, and what a doctor tells or indicates by sign language or a coded message to his/her patient is impossible for the authorities to know.

Awareness of sex determination tests and the PNDT Act

We conducted perception surveys of doctors, Panchayat leaders and married women to get an idea of the awareness of the pre-birth sex determination tests as well as the PNDT Act. Very interesting conclusions have emerged. Almost all women in our survey were aware of these tests, regardless of their literacy and education level, socioeconomic group, caste, etc. In short, there was almost universal awareness of these tests. At the same time, we found that almost all of these women were ignorant of PNDT Act, and they did not know that it was illegal to have the tests done. In Punjab, Haryana and Himachal Pradesh it was our impression that knowledge of these tests had spread like wildfire and even the remotest village dwellers were aware of them. Curiously enough, since 1994 there has been a sharp decline in open advertisements of such tests through newspapers, posters and billboards, nor can such tests be advertised on radio and TV networks. And yet, awareness about the tests is universal, even in remote villages of Himachal Pradesh. This highlights the vital role of person-to-person communication.

Doctors are generally aware of the PNDT Act. They know that it is illegal to conduct such tests and subsequent abortions. The question that arises is: in a situation where the clients are not aware of the legal status of these tests and yet these tests are being conducted, the people cannot be blamed and the **fault lies squarely with the doctors.** The fact remains that in most cases of female foeticide, the clients and

doctors are on the same wavelength, in the sense that both support such tests and foeticide because of the great demand on the part of pregnant women to know the sex of unborn child and the tendency of doctors to make quick money. As one of our leading health activists of Himachal Pradesh, Kshama Matre observed: '*the clapping is real hard when both the hands clap together forcefully as is the case with female foeticide involving motivated doctors and equally motivated clients.*'

Mixing up family planning with female foeticide

As a result of 50 years of propaganda on the merits of a small family norm, there is today general awareness of family planning and the need for adopting a small family norm. Our fieldwork reveals that men and women in Punjab, Haryana and Himachal Pradesh do accept the idea of a two-child family and they are also aware of the technology of pre-birth sex determination tests. As in most parts of India, two sons constitute the cut-off point for accepting sterilisation. The people seem to be quite puzzled that while the government wants a small family norm to be practised, it yet opposes the conduct of these tests and subsequent abortions. *They argue that since every family wants at least one son, if not two, the best way to ensure a small family is to go for the test and act according to the results.* A well-meaning and prominent doctor, having a flourishing private practice in Himachal Pradesh, told us that the government hospitals should allow pre-birth termination tests only in cases where the first child is a daughter. His argument was that in case the second child is a son the family will be satisfied and will opt for sterilisation. This will help in stabilizing the population. The doctor argued that the merit of this formula was that it would reduce quackery and maternal mortality, and would also achieve the national goal of population stabilisation. This doctor had a large private practice and was not at all keen to take on abortion cases, let alone sex determination tests. In fact, he narrated how he was pressurised to conduct this test and abortions by several VVIPs, whose names he could not divulge. In the eyes of the people, there is a dichotomy between the government's sustained advocacy of family planning and a small family norm, with legislation prohibiting the conduct of sex determination tests and sex-selective abortions. This mix-up is the creation of circumstances and neither the government nor the people can be blamed. If an enlightened doctor, who commands great respect and is not a greedy person, genuinely believes that the government should allow such cases and abortions to be conducted on demographic grounds, his views deserve serious consideration. One must pause and think how best to counter such an argument. Under the PNDT Act, very often the Appropriate Authority is the Chief Medical Officer and it is very unlikely that a doctor will prosecute a fellow doctor. One must note the solidarity of doctors in remote areas where social life is confined in playing cards and/or drinking. Besides, it is often pointed out that since a person has to spend so much money in private medical institutions to get trained as a doctor, he is unlikely to forego efforts to make quick money; sex determination tests and abortions provide perhaps the best opportunity to make such money. According to rough estimates of people who are knowledgeable, in many places 90% of the income of several doctors (mostly those in small towns) comes from these tests and abortions. It was clear to us that the legal machinery in the districts was not equal to the task of effectively implementing the PNDT Act, where higher-level officials are busy with pressing administrative problems.

Complexity of re-constructing attitudes and bringing about behavioural change

One gets an impression from seminars and conferences on gender issues that husbands and their parents are pushing their wives and daughters-in-law to go for pre-birth sex determination tests and abortions. Our field surveys, focus group discussions and our own impressions do not lend support to this proposition. We find that many women *themselves* are interested in knowing the sex of the unborn child and they do not see any moral problem in undergoing these tests conducted by doctors: it is like getting blood tests for malarial parasites. Secondly, most women have an inherent son complex. They know for certain that their status—in the eyes of their family, extended family, community and the village as a whole—will go up with the arrival of a son. Gifts will flow in, there will be celebrations and relatives from far and near will call on them. On the other hand, if there is a daughter there is general gloom, no celebrations, no gifts and the image of the woman suffers badly. As one of our senior health activists in Punjab, Mr Manmohan Sharma pointed out 'women are conditioned by social norms and they do not have independent views, they tend to ditto what the husbands say or think and this is considered as proper behaviour for ideal wives'. In such a situation, enforcement of the PNDT Act becomes very difficult. We came across cases of collusion between doctors and clients. The modus operandi is as follows: A doctor from a city or even a small town goes to villages in Himachal Pradesh with his mobile ultrasound machine and in case the sex determination test shows a female foetus, gives the client an address in Pathankot city in Punjab and asks her to report on a Saturday evening when the abortions are conducted in secrecy. This makes it extremely difficult for the Appropriate Authority in Himachal Pradesh to trace (or apprehend) the doctors or the patients for violating the PNDT Act. There were cases in Punjab when the Police arrested some women for undergoing sex determination tests while the doctors went scot-free. This led to an agitation by several health activists and ultimately the women were set free. In the villages we surveyed, there was a lot of apprehension about our study. Even though we conducted our survey with great tact, it was clear to us that women respondents were not telling the truth when they said that they were not aware of female foeticide. At a well-attended meeting for focus group discussion in a village in Punjab, the district-level authorities pleaded helplessness with regard to enforcement of the PNDT Act. It was argued that doctors do not have any idea about the legal provisions of the Act and the Judicial Officer of the district who has to interpret and implement the Act is frequently transferred. Thus, there is no continuity in following up cases and, as a result, nothing gets done.

Networking of government doctors, private doctors, ANMs and dais

During our fieldwork we could sense a silent conspiracy between the government doctors, medical and paramedical staff and private doctors with regard to the illegal practice of sex determination tests leading to female foeticide. The dais and ANMs often act as go-betweens and collect their honorarium (roughly Rs 200 per case). We also suspect that medical representatives are a party to the game of making quick money. One does not have to go to big cities such as Chandigarh, Ludhiana or Shimla to undergo these tests and abortions. Within an ambit of 20–30 km one comes across clinics that undertake such work and have mushroomed under various cover names. The very fact that an ultrasound machine is registered as required by law does not guarantee that it is not misused. A tragic aspect of this is that very

often doctors show utter disregard for medical ethics. They know very well that through ultrasonography it is not possible to determine the sex of a foetus within 12 weeks of conception and yet they conduct these tests and indicate the results (invariably 'it is a girl'). The doctors know that it is just speculation and not scientific observation. In fact, we have come across reports of cases when after abortion it is found that the foetus was male, much to the agony of the parents. One could draw a distinction between a woman agreeing on the suggestion of her husband or in-laws to undergo a test and a woman who, having undergone the test and finding that it is a female foetus, agrees to go in for abortion. Generally, this test is conducted only during the second and subsequent conceptions. But in Punjab, we were told about the recent tendency to go in for these tests *even for the first conception.* There were also cases of murder within the family when the young daughter-in-law refused to go for abortion after the very first conception. According to Dr Betty Cowen, who spent many years at the Christian Medical College (CMC), Ludhiana, 'there was a time in Punjab when the first daughter was welcome, the second was tolerated and the third was eliminated'. We are now facing the tragic prospect of the first daughter being eliminated, what to say of the second and third. Demographers have worked out the sex ratio by order of birth and it is observed that the higher the order of birth, the lower is the sex ratio. Our field data also confirm this. There is no doubt that if this trend persists for another two decades, States such as Punjab and Haryana will face disastrous social consequences.

Economic prosperity and social backwardness

States such as Punjab, Haryana and Himachal Pradesh are not socioeconomically and demographically backward, the attitude towards the girl child is alarmingly unprogressive. Our fieldwork leads to the conclusion that there are at least three pre-conditions for the spread of female foeticide: (i) easy access to medical facilities, in particular, ultrasound and abortion facilities; (ii) ability to pay the doctor and abortionist for the test and abortion; and (iii) a good network of roads to cut down the cost and time of travel and the time taken to travel. These conditions are generally fulfilled in our study areas, e.g. in the Fatehgarh Sahib district of Punjab, which has the lowest child sex ratio in India (754), the villages are prosperous, the transportation network is very good and there is easy access to medical facilities, particularly in Ludhiana (Fatehgarh Sahib was once a part of Ludhiana district). Above all, the dominant Jat community is historically known for its son complex. On the other hand, in Kerala, even if these three conditions are fulfilled, it may not trigger off a spate of female foeticides because of the absence of the son complex, though of late, it has been observed that if a couple opts for one child they would rather have a son than a daughter. In the southern States, there is growing evidence that people would be content with one son and one daughter and would not go on with repeated pregnancies with the hope of getting sons as in the north. While doing fieldwork we did come across tragic cases of numerous abortions in women desperately looking for a son, even after giving birth to five or six daughters. The adverse impact on the physical and mental health of mothers can be imagined. The 2001 Census data also reveal that in tribal-dominated districts, the son complex does not dominate the social ethos, and girls are valued. In northeast India too, the son complex is less prevalent. One distressing question that arises in this regard is: with a higher level of economic growth, better income levels and better transportation networks, will **all** States follow the footsteps of Punjab, Haryana and Himachal Pradesh leading to further declines in the child sex ratio?

Causes of female foeticide

We also tried to ascertain the causes of female foeticide through our surveys. The general perception is that the cost of marriage and dowry has gone up and so daughters have become greater financial liabilities. The dowry system is invariably blamed. We are not convinced that dowry alone is the main cause of female foeticide. Families that are well off and do not have to depend on dowry to augment their income are also opting for female foeticide. The real reason seems to be the high status of families with several sons and the low status of families with no sons. Another interesting factor for the preference for sons is that the prospect of migration of sons to, say the Gulf or western countries, is much higher for men than for women (except in special cases such as Kerala from where nurses who go all over the world). In the eyes of the local community, any family with children abroad has a higher status and certainly a higher income level than non-migrant families. Globalisation is thus adding to the miseries of the girl child.

In short, there are numerous causes for the spread of female foeticide and it will be unscientific to believe that dowry alone is the cause, as is the general perception. Our perception surveys did reveal that people are aware of the upward swing in dowry demand and the rising cost of marriage. Greed has increased in our society and numerous TV channels and endless advertisements increase the greed further.

Female foeticide: a symptom of increasing crime against women

It would be manifestly wrong if we conclude that female foeticide is a matter of medical technology alone. There is no doubt that easy access to ultrasonography has been largely responsible for the spread of female foeticide throughout the country. During our fieldwork, we realised that many women suggested female foeticide not because they were heartless but because they were genuinely concerned about the fate of girls who are increasingly being subjected to eve-teasing, molestation and sexual harassment and, after marriage, exposed to the risk of bride burning and dowry death, in the unending demand for dowry from our emerging consumerist society. This calls for a good look at gender issues in all their ramifications in our increasingly dysfunctional society.

Sex Ratio and Birth Order in Punjab and Haryana

Background

Several demographers have made technical comments on the declining child sex ratio (0–6 age group) revealed in the 2001 Census. For example, Ashish Bose, P.N. Mari Bhatt, T.K. Roy and Fred Arnold have, in their contributions, analysed this disturbing phenomenon.

Ashish Bose has coined the term DEMARU to denote 'Daughter Eliminating Male Aspiring Rage for Ultrasound'. Mari Bhatt in his paper **'Vanishing women and surplus men: The demography of falling sex ratios'** maintained that (i) female foeticide would lead to greater destruction of the sex ratio in States such as Punjab, Haryana, Rajasthan and western Uttar Pradesh; (ii) the rising proportion of male births is one of the reasons for the acceleration in the fall of child female-to-male ratio (FMR) after 1981; and (iii) the pattern of the sex ratio at birth by order of birth implicates the role of female foeticide, and there is a stronger basis for assuming that female foeticide caused fertility decline in States such as Haryana and Punjab rather than the reason that the fertility decline in these two States is caused by a fall in the desired family size.

In their recent paper entitled **'Sex ratios and sex-selective abortions in India: Findings from the 1998–99 National Family Health Survey'** Fred Arnold and T.K. Roy observed that (i) in every State except Meghalaya, the sex ratio of last births is much lower than the sex ratio of other births; (ii) for all-India, the sex ratio of last births is 697 and the sex ratio of other births is 936; (iii) for the high son preference states of Punjab, Haryana, Gujarat and Maharashtra, the sex ratios are 561 for last births and 998 for other births; (iv) even in the low son preference states of Tamil Nadu, Kerala, Karnataka and Andhra Pradesh, there is a substantial differential (821 vs. 983); and (v) the biggest differential is in Punjab, where the sex ratio of last births is 460 and sex ratio of all other births is 991.

Methods

The following analysis is based on field observations from the States of Haryana and Punjab. Kurukshetra and Fatehgarh Sahib and three villages of these districts were selected for the study. A household health survey was conducted in these six villages covering all the households in the villages and information was collected on various issues such as women and child health, migration, abortion, education, etc. In Haryana, 550 households were covered under the health survey where as, for Punjab, total 582 households were covered from the respective villages. Hence, collectively 1132 households were covered from six villages in the two States studied .

It is worth mentioning here that these two districts were selected keeping in mind the fact that these districts have the worst sex ratio among children 0–6 years of age in the

respective States. Though a wide range of information was collected through the household health survey, here, this **analysis primarily focuses on the correlation between the sex ratio and birth order**. Some highlights are given below.

Table1. Background characteristics

Variables	Haryana		Punjab	
	Frequency	Percentage (%)	Frequency	Percentage (%)
Family type				
Nuclear	287	52.2	538	92.4
Joint	263	47.8	44	7.6
Annual household income in Rupees				
< 12,000	53	9.6	3	0.5
12,000–24,000	152	27.6	148	25.4
24,000–36000	107	19.5	111	19.1
36,000–48,000	48	8.7	100	17.2
48,000–60,000	26	4.7	56	9.6
>60,000	161	29.3	163	28.0
Does not know	*	*	*	*
Religion				
Hindu	421	76.5	88	15.1
Muslim	*	*	29	5.0
Sikh	127	23.1	465	79.9
Occupation of head of the household				
Farmer	223	40.5	191	32.8
Laborer	217	39.5	290	49.8
Service Holder	65	11.8	53	9.1
Business	42	7.6	35	6.0
Others	3	0.6	13	2.3

*Negligible

- Looking into the background characteristics, it is clear that in Haryana, almost half (48%) of the households are joint families whereas in Punjab only 8% of the households are joint families.

Considering the annual household income, it can be observed that the number of households having an annual income more than Rs 60,000 is about the same in both the States. Among households having an annual income of less than Rs 12,000, it can be observed that in Haryana about 10% of the households fall in this category, whereas in Punjab, less than 1% of the households are in this category. From this it can be concluded that, overall, Punjab is in a better situation than Haryana in terms of annual household income.

- Hindu families predominated in Haryana whereas in Punjab there are significantly more Sikh families.
- For both the States it can be observed that the head of the household is either a farmer or a labourer.
- The age distribution of the women shows that in Haryana about half (48.5%) of the women belong to the age group 25–34 years. In Punjab a little less than 40% of women belong to this age group.
- The level of education is quite low in both Haryana and Punjab. In Haryana, 66% of the women are illiterate which is substantially higher compared to that in Punjab where 55% women are illiterate.
- Although the total number of living children is similar in both the States, Punjab is a little

better. In Haryana, half of the women (50%) have three or more children, while in Punjab, 41% of women have at least three living children.

After profiling the households and women's characteristics in the studied States (Tables 1 and 2), we carried out further analysis to understand the correlation between the sex ratio and order of birth.

*Number is very small (only one son and no daughter) **The number of sons for this age group of mothers is 84 whereas no daughters were found for the fourth and higher-order births among mothers below 25 years of age

- In Haryana, for first-order births, the sex ratio gradually declines as the age of the woman increases. In Punjab, except for the below 25 years age group of women, the sex ratio depicts a similar picture as that in Haryana.
- For other birth orders, Haryana reflects a similar picture of declining sex ratio as the age of the woman increases, except for the age group below 25 years.
- Though Punjab does not strictly follow this pattern, it is more or less similar.

Table 2. Demographic characteristics of married women

Selected characteristics	Haryana		Punjab	
	Frequency	Percentage	Frequency	Percentage
Women's age (years)				
Below 25	74	13.5	84	14.4
25–34	267	48.5	224	38.5
35–44	143	26.0	196	33.7
45 and above	66	12.0	78	13.4
Women's education				
Illiterate	**365**	**66.3**	**321**	**55.1**
Class I to Class IX	127	23.1	163	28.0
Secondary (X completed)	40	7.3	79	13.6
Higher Secondary and above	18	3.3	19	3.3
Number of living children				
One	86	15.6	127	21.8
Two	190	34.5	217	37.3
Three	163	29.6	145	24.9
Four and above	111	20.3	93	16.0
Total	550	100.0	582	100.0

Table 3: Distribution of sex ratio with women's age at various birth orders

Birth order by mother's age	Sex ratio	
	Haryana	Punjab
First order		
Below 25 years	1354	750
25–34	1007	1018
35–44	881	585
45 and above	320	300
Second order		
Below 25	258	240
25–34	991	864
35–44	792	946
45 and above	558	851
Third order		
Below 25	571	500
25–34	984	759
35–44	583	662
45 and above	560	375
Forth order and above		
Below 25	—*	0**
25–34	733	98
35–44	525	145
45 and above	391	

- For the fourth-order births it is observed that the sex ratio is substantially low for women of all age groups in Punjab.

Table 4. Sex ratio (female per 1000 male) at different birth orders

Sex ratio	Haryana	Punjab
First order	890	698
Second order	787	830
Third order	743	664
Fourth order and above	577	96
Overall	**787**	**458**

- The sex ratio for different birth orders in Haryana shows that the sex ratio follows a sharp decline from the first-order birth to the fourth and above order.
- The sex ratio for fourth and above order births is considerably low. This means that majority of the couples who go for fourth-order births desire to have a son only.
- The sex ratio for different birth orders in Punjab tells a similar story. Except for second-order births, it can be observed that the sex ratio otherwise maintains a sharp decline from the first-order births towards those of fourth and above order.
- What is more important is that attention must be paid to fourth and above order births. In Punjab, the sex ratio declines drastically from the third-order births to fourth and above order births. The sex ratio is only 96 for fourth and above order births, which is alarming.
- Even, if we will look into the over all sex ratio for both the States, it can be observed that for Haryana, the over all sex ratio is 787 which itself is quite low, but, for Punjab, it is only 458.

Discussion

- Generally, it is believed that Punjab and Haryana can be bracketed together as regards economic development. However, our data, based on detailed study of three villages in Haryana comprising 550 households and three comparable villages in Punjab comprising 582 households, bring outstanding results. In Punjab, 92% of households belong to nuclear families, whereas in Haryana only 52% of families are in this category. This phenomenon itself calls for an in-depth investigation, which we were not able to do in our present study, as it focused on female foeticide.
- We have also collected data on annual household income. As is well known to all economists, perhaps the most important item in such a survey is data on income, which tends to be unreliable through the direct questionnaire method. Nevertheless, we attempted to collect data on household income and the results are very interesting.

The annual household income data confirm that Punjab is more prosperous than Haryana. But, among those whose income is more than Rs 60,000 per year, the percentage of households is quite similar for both the States, i.e. 29% in Haryana and 28% in Punjab. However, in the income category of below Rs 36,000 per year, we find that in Haryana 57% fall in this category compared to 44% in Punjab. This has important implications for our study on female foeticide. It confirms that even at the grassroots level, the practice of female foeticide is more prevalent in Punjab than Haryana. In short, it is induced by prosperity and not by poverty. This goes against the theory of demographic transition, which expects rational behaviour on the part of the better educated, higher income group and 'modern' families, which are limited in Punjab. Add to this the higher level of emigration to foreign

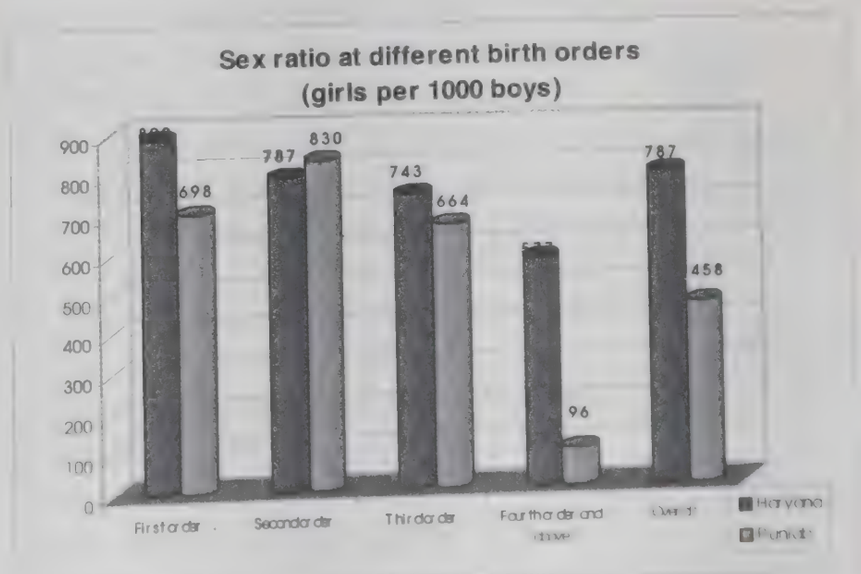
countries from villages in Punjab compared to those in Haryana; this leads to a higher level of exposure to the West and a greater interaction among relatives and friends settled in foreign countries such as the USA, UK, Australia, Canada, etc. It may also be noted that these foreign countries do not have any prejudice against the girl child, which is so common in traditional India. In short, technology and modernisation have not yielded the desired results in the social sector: technology has only fuelled 'tradition' by misusing medical technology and perpetuating social customs such as dowry. However, to arrive at a firm conclusion intensive socio-anthropological studies are needed.

- Ø The data on education show that the proportion of illiterate women is lower in Punjab compared to that in Haryana. Nevertheless, there is no evidence that education is an important contributing factor to female foeticide.
- Ø The data on age of the women and birth order convincingly indicate that there is absolutely no desire for a daughter in third and higher-order births. Table 4 clearly brings out the negative correlation between birth order and sex ratio. In Punjab the figures are much lower than Haryana. Even the overall child sex ratio for all birth orders for Punjab is only 458 compared to 787 in Haryana. In short, there is convincing evidence that the phenomenon of female foeticide is indeed widespread in Punjab. For technical reasons we have not been able to analyse the birth order data of Himachal Pradesh, which will be done subsequently. However, it would be unwise to bracket all the three States together.

It is evident from the univariate analysis that people follow different lifestyles in Punjab and Haryana. Punjab has largely nuclear families and is also economically better off compared to Haryana. At the same time, these two States show diverse cultures. Haryana has predominantly Hindus while Punjab has more Sikhs. Compared to Punjab, the educational level of women is lower in Haryana. Thus these two States cannot be categorised together.

It is apparent that the sex ratio has declined drastically over a period of time in the two States studied. After correlating the sex ratio and different birth orders it was observed that the sex ratio follows a declining trend from the first birth order to the fourth and above birth order. Roughly, both the States have a similar trend. Moreover, though, for the fourth and above order births the sex ratio is significantly low for both the States, comparatively Punjab depicts a worse picture than Haryana. *This extremely low sex ratio for fourth and above order births could possibly be due to the fact that only couples who want to have a son opt for more number of children.*

Our household health survey data as well as the focus group discussions also confirm that Punjab has indeed the worst case scenario as indicated by the 2001 Census. This validation of the Census data on child sex ratio through careful field surveys only prompts us to say that serious efforts should be made to analyse the Census data on child sex ratio in all the districts and States of India so that one can make policy interventions on the basis of scientific analysis.



Chapter 8

Highlights of the Interactive Workshops

Organised by VHAI in collaboration with State VHAs and other organisations

Much before the 2001 Census, VHAI started serious work on the issue of female foeticide by focusing on the worst affected States showing the maximum decline in the female-to-male sex ratio. Voluntary Health Association of Punjab started as early as 1998 with a baseline survey in 20 villages from the three districts of Punjab (Patiala, Fatehgarh Sahib and Ropar). This was followed by several regional-level workshops aimed at the prevention of the rampant phenomenon of female foeticide in Punjab, Haryana and Chandigarh. These workshops had participants from all levels, i.e. government, NGO, medicine, law and other professions, with a massive representation of the local people. National bodies such as the Human Rights Commission, Delhi; National Commission for Women, State Commission for Women, Punjab; Human Rights Commission, Punjab and other agencies such as NFI, New Delhi had also participated in these workshops.

Besides these efforts at lobbying, a series of meetings were held with people's representatives, i.e. Mahila Mandals, women activists and Panchayat members and health activists at various places in Punjab. **The following section briefly summarises the viewpoints of various stakeholders.**

Lawyers

- One of the leading advocates feels that *'The ultrasound technique was initially developed to monitor the health status of a child in the mother's womb. The technique was soon being misused rather than used to determine the sex of the unborn child. Despite the enactment of the PNDT Act in 1994 to curb the practice, it continued by both registered and many unregistered medical practitioners. Our male-dominated society is more concerned about making quick money. Women have always been discriminated against and looked down upon. Improvements are not possible by only making laws. The situation will improve only when mothers themselves treat their children with equality.'*

Doctors

- Doctors feel that, *'dowry is the main cause of female foeticide. To curb this practice it is important to vow against marrying our daughters to those demanding dowry. Parents must educate their daughters and give them proper nutrition and an equal status since birth, to save them from exploitation tomorrow.'*

- One of the lady doctors asserts, *'Bhrun hatya manavta ke nam par kalank hai* (female foeticide is a stigma on the name of humankind). *To negate a woman's identity is to challenge one's identity. People are abandoning moral norms and values and indulging in immoral acts.' She further questioned, 'Was it only the man*

Highlights...

who was responsible for the act of aborting a female foetus or was the woman (mother to child) equally responsible? And if the woman was responsible then what are the circumstances that compel her to kill her own girl child? Is she compelled by her family/society to go for abortion or is it her own decision? She feels that *'there is a need to go deeper to know the real reasons responsible for this phenomenon. And if the practice of killing female foetuses is not eradicated there would be a sure spurt in crime against women in the form of rape, eve-teasing, forced polyandry, etc.'*

- According to a senior cardiologist, some of the reasons for the presence of so many ultrasound clinics in the city were the following:
  - *having an ultrasound machine was considered as a status symbol by doctors*
  - it was an easy way to earn more in less time
  - *local manufacture of ultrasound machines had reduced the basic cost.*

- Another successful doctor mentioned that, *'An interesting reason behind the increase in the number of abortions in Bhatinda, Punjab is the fact that people feel ashamed to be known as the brother of a girl as they are then expected to tolerate the behaviour of their sister's husband no matter how much land-holding they have. To be known as a 'salla' is degrading so they prefer to have brothers only and not sisters'"*

- A civil surgeon told the VHAP team, *'The main reason of the adverse sex ratio in Bhatinda was illiteracy. People with much land holdings never preferred to enter any other type of employment and, for this very reason, did not consider it necessary to educate themselves or their sons. Womenfolk were mainly compelled by social pressures to get the sex of the child determined, no matter how expensive it was for them. The birth of a son ensures a sense of security for the parents.' He informed that there were 40 clinics, all unregistered, where (without publicity) sex determination tests were carried out.*

- A well-known doctor, who had opened one of the first ultrasound clinics in Bhatinda retorted, *'There are many factors responsible for the decline in the female-to-male sex ratio. Social and family pressures have made women themselves favour sons. And this involves all middle, lower and educated classes. In such families, if the first child was a daughter then second ought to be a son.'*

- A registered medical practitioner who has been practising in Hassanpura since 1984 thinks that *'People are mainly scared of the high dowry and it was this factor that drove them to selectively abort female foetuses and desire a son. No doctor has ever popularised or advertised ultrasound. Women come to the doctors out of their own choice. Therefore, doctors must not be seen as culprits, though they are benefiting financially from this situation.'*

- The views of a lady doctor: *'Women themselves were responsible for the decline in the female-to-male sex ratio as they believe that only by giving birth to a son could they secure a better position in their in-laws' home.'*

Other Voices

- **Shri Ajmer Singh Mann** (Secretary, District Bhatinda) said, *'As agriculture was the main economic activity in Bhatinda, a son who could later become a helping hand was the preferred choice. Besides the economic reasons it was the son who could look after parents in their old age and who would inherit the family property and name. Also, to avoid the heavy expenditure in marrying off the daughter people chose to kill her at the time of conception itself, not permitting her to see the daylight.'* He stated that two main reasons were responsible for the decline:

  - With the district having an agrarian economy and to take care of their parents in old age, sons were the preferred choice.
  - To escape the huge dowry and marriage expenses required for a girl child people chose to kill them at the time of conception itself.

Vhap Findings

- Although Punjab has a comparatively better literacy rate (69.95%), VHAP's findings suggest that literacy has nothing to do with the rampant occurrence of female foeticide. It was found that, of the various districts of Punjab, Hoshiarpur with a maximum literacy ratio (81.40%), the sex ratio (number of females per 1000 males) in the 0–6 years age group which had declined to 54 in 10 years, i.e. as per the 1991 Census there were 864 females/ 1000 males which has been reduced to 810 females per 1000 males.

- During a field survey in the Padhri Kalan district of Amritsar it was realised that the village women had a basic feeling of deprivation, as if they were all living under pressure in a patriarchal society. Though outwardly they looked happy, deep down they were suffering due to various personal and social problems. They expressed the need for some social and moral support.

A sample of case studies done by VHAP

1. Family discord due to the birth of daughter. Mamta (20 years old) has an eleven-month-old daughter. She told the VHAP team that during her first pregnancy she was blessed by all family members, friends and neighbours to have a son, and was also taken to Baba Pannu by her sister-in-law to fulfil their desire to have a son. With all these blessings and a sacred apple, Mamta still gave birth to a daughter, which adversely affected her married life. She was told by her much annoyed husband that the next time they would go for an ultrasound test. *Now she too wants her second child to be a son.*
2. Smt. Sunita, belonging to a lower socioeconomic class, has three daughters the eldest one is three years old, second is two and the youngest is four months old. She feels that only a son can bring happiness to her family, as only he can look after the parents in their old age, inherit the family property and carry forward the family name. She told us that since the birth of her second daughter her husband had started abusing her over household expenditure.
3. Sarabjeet Kaur (22 years old) belongs to a Sikh family from this village and was married in the village of Thoundi. She has two daughters. The eldest is one–and-a-half years old and younger is 6 months old. She said that since the birth of her second daughter she has been living with her parents as no one from her in-laws' house came to see or take her back. *She believe*

that if she had given birth to a male child her situation would have been a happy one.

Samgauli

It was reported that in one year in Samgoli village, district Patiala, for every ten boys only five girls were born. The team from the VHAP visited the village, which was mainly inhabited by Rajputs. The woman Sarpanch, Smt. Kamala Devi informed the team that with easy accessibility and availability of ultrasound facilities, every woman in the village was aware of ultrasound techniques. The team also found that some dais in the nearby village of Kukkar Majra were giving certain medications to ensure a male child to pregnant women.

Himachal Pradesh Voluntary Health Association (HPVHA)

The release of Census 2001 showed a sharp decline in the child sex ratio (0–6 years age group) in almost all the tehsils of Himachal Pradesh, which in some places was as low as 723. HPVHA took immediate note to discuss the reasons/factors behind the problem and prepare an action plan for its prevention and control. A **State-level Seminar on Declining Sex Ratio** was organised on 25 July 2001, attended by chief functionaries from the voluntary organisations (VOs) throughout Himachal Pradesh and adjoining States, delegates from government departments, educational institutes and media personnel.

This was duly followed by the formulation and implementation of an action plan by HPVHA.

Main Actions Taken by Hpvha

- Collection of information from various sources on the subject. The Census data were analysed and sent to various VOs in HP and other concerned agencies outside HP.
- A consultation of governing body members took place where a further action plan was chalked out. Field NGOs (FNGOs) under the HPVHA Mother NGO (MNGO) programme took up 'awareness-generation' activities as an integral part of their programme. Posters sensitizing the public about foeticide and girl child problem were developed by VHAI, New Delhi and circulated among MNGOs, FNGOs and other concerned agencies.
- 'Sensitisation on gender issues' was the main agenda of the subsequent AGBM HPVHA, where various field VOs under the MOH&FW MNGO RCH programme took a pledge to initiate mass awareness activities on their own.
- Being an HP State and District PNDT Advisory Committee Member, HPVHA maintained regular interaction with PNDT implementation authorities in the State.
- A Newsletter focusing on key issues of the 'declining sex ratio' was published and circulated within and outside the State. Various posters and educational material was also disseminated to the community at large, media, and exhibitions.

As a follow-up measure, another Consultation on the 'Declining Sex Ratio' was organised on 3 September 2002 by HPVHA to review the earlier actions, experiences and develop a plan of action by taking stock of the existing situation. The following section briefly presents the perspectives expressed during these consultations organised by HPVHA

Government Functionaries

- Smt. C.P. Sujaya (former Additional Chief Secretary to Government of Himachal Pradesh) expressed her concern over the

sharp decline in the child sex ratio as revealed by the 2001 Census report, saying, *'there is a need to look behind the social reasons responsible for the enactment of the PNDT Act, as implementing the Act alone cannot curb the social menace of female infanticide and foeticide. It is the problem of discrimination against women and the girl child, which is the root cause of this problem. Of late, society has started rationalising this discrimination, saying this form of discrimination is better than that (i.e. foeticide is better then infanticide, a low guilt option). Also, there is a growing belief that the first daughter is still welcome but no more. The argument behind the belief is that one daughter can be looked after well. Hence, birth order is an important determinant for discrimination.*

Smt. Sujaya further posed a question about the justification of solving one discrimination (dowry) by resorting to another (foeticide). The *medical community also needs to be exposed to social issues, as the issue needs to be dealt with comprehensively at all levels.* Ms Sujaya suggested, *'The health department should try to find a relationship between antenatal care and ultrasonography, between ultrasonography and MTP and linkages between family planning and decline in the child sex ratio.'*

Doctors

- Dr S.K. Gupta (State Council for Science Technology and Environment) expressed, *'There is an urgent need to increase awareness about these issues through the various channels of the mass media; Doordarshan and All India Radio need to be utilised effectively. Also, the success stories where parents have only girls should be collected and given wide publicity.'*
- Dr K.S. Tanwar (Director, State Resource Centre, Shimla) pointed out, *'there is a general lack of political will to deal with the issue of declining child sex ratio. No government department is ready to take the lead even for coordinating women-related activities.'*
- Dr C.D. Sharma (HP State AIDS Control Society) suggested, *'time-bound strategies and plans should be formulated as the problem hast serious future implications. As the law alone would not be effective educational and engineering efforts with a focus on intersectoral coordination should be taken immediately.'*

Focus Group Discussions in Kangra district, Himachal Pradesh by VHA field team

On the basis of our focus group discussions with the people in the villages we studied, we got valuable insights into social reality. We present a few highlights below.

No impact of education on dowry demand

There has been a general improvement both in the level and status of education among girls in the village and it was unanimously felt that girls were better performers in studies. But it had no made any impact on the rising cost of marriage and increasing demands for dowry.

Spread of female foeticide in rural areas

Female foeticide is widely prevalent in the villages. The commonly mentioned reasons are: son preference, difficulties in raising a girl child, increasing dowry demands, availability of ultrasound and abortion facilities in nearby private clinics. In this context, it is worth noting that villages in Himachal villages have a good exposure to the outside world. Men migrate in large numbers to the cities, join the army but retain contact with their own

villages. There are even prosperous people settled in Kolkata who regularly visit their homes in villages in Himachal Pradesh. Most of the houses in the villages we studied have telephone, TV and cable facilities. Most of the houses were also *pucca* houses with water and electricity. In such a situation, the spread of female foeticide is to be expected. The rural scene in Himachal Pradesh is unlike that in most other States of India.

Increasing crime against women

There is a feeling that eve-teasing and molestation were widespread and crime against women is increasing. Some of the reasons mentioned are the rising unemployment levels among the youth, deduction in quota of army recruitment and addiction to alcoholism.

Marriage and family size

Inter-caste marriages are strongly opposed though there are a few cases of 'love marriages', which were within the same caste. Most villagers, both men and women considered a *two-child* family as ideal and the preferred choice is *one boy one girl.* Most persons thought that there must be at least one son. There were only one or two persons who did not bother about the sex composition of their children.

Increasing suicide rate

According to some knowledgeable doctors, there is an increase in suicide rates among both men and women in Himachal Pradesh. Suicides amongst married women are mainly from Rajput families during the long absence from home of husbands when their young wives are tormented by the in-laws. There are several cases of dowry deaths triggered by mother-in-law syndrome but there has not been a single case of a mother-in-law dying.

Women: Victims of circumstances

We came across several cases of women themselves wanting to know the sex of the unborn child and also opt for sex-selective abortion. The general feeling was that it was not true that women were always compelled by the in-laws and husband, as it is well known that the social status of a woman improves with the arrival of a son. In this context a question was raised 'Why do educated women go for sex-selective abortion even when they are under no compulsion from the family.' It was observed that women from high-income families took the lead role in matters of pre-birth sex determination leading to female foeticide. It was also noticed that social protection of girls was becoming difficult due to the increasing gender violence.

Chapter 9

Media Concerns...

Media Concerns about Female Foeticide

We scanned a number of national dailies and magazines to study the print media coverage of news and views relating to female foeticide. Perhaps the most important coverage was of the proceedings of Supreme Court, their orders and subsequent developments vis-à-vis State Governments, NGOs and others. It may be recalled that when a PIL was filed by some NGOs (CEHAT and MASUM and Sabu George), the ball started rolling. However, though the PNDT Act was passed in 1994, nothing much happened by way of implementation. The first results of the 2001 Census of India revealed a shocking phenomenon, namely, a sharp decline in the child (0–6 years) sex ratio from 945 in 1991 to 927 in 2001.

In spite of the PNDT (Regulation and Prevention of Misuse) Act, 1994 *it seems to us that India's baby girls are fast disappearing due to legal loopholes and the law is not enough.* Professional researchers and demographers analysed the data in detail and commented on this social menace in technical papers. Likewise, there was increasing coverage of female foeticide and related issues in the popular press in the form of features, articles and editorials. In the following pages we give some highlights of the print media coverage.

SC Judgment on PNDT Act and Subsequent Developments with regard to SC

—**The Tribune** accorded a fairly good coverage to female foeticide. Rajan Kashyap, Principal Secretary, Department of Health and Family Welfare, Punjab (**Tribune**, 21 January 2002) wrote in his article entitled 'We are sowing seeds of our own destruction' that '*The enactment of PNDT Act does not lend itself to any neat acronym, nor, as it has transpired, to effective implementation.*'

—In December 2001, CEHAT, MASUM and Sabu George filed a PIL in the Supreme Court regarding the failure of the Health Departments of 11 States in implementing the existing law against the misuse of sex determination tests. Health activist Sabu George claimed that 'instances of "femicide", which include female infanticide, sex-selective abortions and sex selection of embryos, were on the rise despite the enactment of the PNDT Act.' Petitioner's counsel Indira Jaising argued that the '*State Governments have been casual about granting licenses to ultrasound clinics.*' In response, the Bench said that the authorities should not grant certificates of registration if the application form is incomplete. Attorney General Soli Sorabjee appearing for the Centre, also held that the 'State Governments were responsible for the implementation of the Act.'

—The Supreme Court summoned the Health Secretaries of 11 major States to identify the clinics where sex determination tests were illegally conducted and asked five multinationa

concerns. Philips, Symonds, Toshiba, Larsen & Toubro and Wipro GE, which supply ultrasound machines, to give the names and addresses of the clinics and persons in India to whom they had sold their machines in the past five years. The States were also directed to provide district-wise data on ultrasound clinics and to publicise the constitution of district advisory committees.

—**The Hindu** in its editorial remarks said that *'The series of hearings on the relevant PIL has also laid bare the slackness in executive action that has characterised the role of State Governments in implementing the provisions of PNDT Act.'* (1 February 2002).

—**The Hindu** suggests the proposed amendments to the PNDT Act, 'Enhancement of penalties for violation, presumption of innocence of women undergoing sex determination tests and a mandatory stipulation that clinics maintain records of scans are some of the amendments that would have to be adopted to ensure effectiveness of the law.' (1 February 2002).

—The editorial in the **Indian Express** (31 January 2002), with the headline 'Femme Fatal; States have to get their Act Together on Female Foeticide', *viewed State Governments as important role-players for the effective implementation of the PNDT Act especially in light of the SC Directives. It reported, 'A State like Punjab, where sex determination tests and female foeticide is almost endemic, listed only 630 clinics and had taken no significant action.'*

In their PIL, the petitioners asked for the inclusion of pre-conception sex-selection techniques within the purview of the Act. They also asked for a ban on advertisements promoting the use of sex-selection techniques.

—**Indian Express** reported that 'In the absence of any provision in the Act banning the use of PGD techniques, Delhi High Court Counsel, Mala Narayan, *pointed out that Gen-Select can be otherwise prevented from being sold in India since it can be inferred as infringing on the Right to Equality under Article 14 of the Constitution.'* (16 November 2001).

—Affirming the need for an amendment in the existing law, A.R. Nanda, the then Union Family Welfare Secretary, has been quoted by Kalpana Jain as saying, *'IVF Clinics have mushroomed all over. In the name of infertility techniques, all such practices are being carried out.'* (**Times of India,** 5 June 2002).

—An editorial in the **Telegraph,** Kolkata, entitled 'Found Wanting' claimed that 'Economics does have a part to play and poverty is not responsible for the country's worsening gender ratio.' (30 December 2001)

Marriage, dowry, dowry deaths, etc. including bride price

—Kanwarjeet Kochchar, a Chandigarh-based gynaecologist, in her article 'Make life worth living for the girl child' stated, 'In my thirty-year long practice there has been a remarkable improvement in technical and other social sectors with women excelling in every field but the only thing which has not *changed is the attitude of our society towards the suffering of women and the ever-growing lust of a male issue, being considered the waris of the family.* The girls are *paraya dhan* who will go to their in-laws house and carry their name. People often say: *"Daktar saab koi changi cheez deni see."'* (**Tribune,** 21 January 2002).

—An article on the editorial page of the **Statesman** reported that *'In the rural areas of the North where life is still feudal, woman are seen as a burden because of huge dowry*

demanded at the time of marriage. The menace of dowry puts across the divides of caste and culture. A male child is also seen as an insurance policy of the old age, and who will inherit and carry on their family name.' ('Female Infanticide—Gender Discrimination Still Rife', 15 July 2002).

—An editorial in the **Times of India** argued that, 'Apart from economic utility in Punjab both social and religious utility weighed in favour of sons.' ('Womb Raiders', 20 September 2002)

—Anuradha Dutt in her article 'Travails of the Girl Child' stated, '*Ours is a staunchly patriarchal society that reports a high incidence of violence against women, including rape and dowry deaths,*' and quoted sociologist Rina Dhar who commented, '*Patriarchy in India is so strong that traditional man–woman relations are deeply embedded in the psyche.*' **(Pioneer)**

—Rashme Sehgal reported, '*Another adverse impact of a skewed sex ratio could be "wife-sharing" or something like "Grooms go begging in Haryana—female foeticide forces them to buy brides from other States."* (**Times of India,** 10 November 2002).

—The Statesman, in its edit column observed: 'The only answer to combat the prevalent *gender discrimination is literacy, education and raising awareness.*' (15 July 2002).

—In contrast, the editorial column in the **Times of India** argued, 'Neither education nor affluence (Punjab, Himachal Pradesh, Haryana and posh colonies of Delhi showing maximum decline in the female:male child sex ratio) has any significant impact when it comes to the girl child. Therefore, if the girl's parents or family is unable to provide dowry, the girl, even if she is educated, is doomed to remain unmarried.' ('Womb Raiders', **Times of India**, New Delhi, 20 September 2002)

—Mrinal Pande in her article, 'Whose womb is it anyway?', stated, '*It is important to increase the space of women within families for them to have an access to their reproductive and sexual rights and to enhance their role in decision-making.*' (**Pioneer,** 21 December 2001)

Differing views of doctors

—The amendments to the PNDT Act to curb the practice of female foeticide were resisted strongly by a powerful lobby of the doctors. The **Tribune**, which gave substantial coverage to the issue in its national and State dailies, carried mainly legalistic comments.

—Nevertheless, the medical code needs to be amended, as reported by the **Deccan Herald** that 'it would be too fast to forget the public confession made by a Mumbai-based doctor of his violation of Human Rights on a foreign TV channel, making it imperative that persons like him could be brought to book only after the apex court's order as the medical code of ethics did not have provision to take action against doctors practicing female foeticide.' (**Deccan Herald**, Bangalore, 18 March 2002; 'NGO moves court over MCI's failure to check foeticide', 18 March 2002).

—A number of newspapers, such as the **Deccan Herald** and **Kashmir Times,** reported, 'Supreme Court's claim to the MCI to amend the medical code to prosecute erring doctors, and *also urging the Medical Council to include an oath against female foeticide.*'

—In June 2002, three national dailies—the **Indian Express, Statesman** and **Pioneer**—and one State daily **MP Chronicle** (Bhopal) covered by us, gave one article each reporting, 'The disagreement of the Delhi Medical Association and IRIA doctors against the proposed amendments in the PNDT Act.'

—The **Hindustan Times** featured a special article on its editorial page by a woman journalist Arundhati Roy Choudhury. The article discussed the various sociomedical dimensions of female foeticide, arguing that technology does not exist in vacuum and its use is dominated by the social and cultural context (25 October 2002).

She further posed the following question, '*Why do the doctors with good intentions not want regulations? Women should have a right to abort their unwanted foetus, but the use of technology to selectively eliminate the female foetus is questionable.*'

This article made it very clear that sex determination has to be viewed as a social issue rather than a woman's issue.

Chapter 10

Recommendations

We examined briefly the causes of female foeticide as perceived by doctors, panchayat members and married women in the villages that we studied intensively and give the highlights of our findings. In a country of India's size and diversity, it would be unrealistic to come out with uniform recommendations that would restore the gender balance. Nevertheless, we have made several suggestions at the national, State and local levels to fight the menace of female foeticide.

We clearly recognise that the whole issue of female foeticide has to be understood in the wider context of gender issues and increasing violence against women and not merely in terms of evolving medical technology and the consequent attempts to suppress its misuse by invoking the PNDT Act of 1994 with amendments in 2002. There are limits to what the law can do. We have the sad experience of the ineffectiveness of the Child Marriage Restraint Act, Dowry Prohibition Act and similar other legislations to combat social evils. Legal action can certainly be a powerful deterrent to irregularities on the part of doctors and paramedical staff, both in the Government and private sectors, but unless the law is implemented ruthlessly and backed by relentless social action with the fullest involvement of men and women with vision, the situation may indeed worsen.

At the conceptual level, one must realise that while gender balance is a worthy macro objective, at the family level, it often becomes a rhetoric. Millions of men and women stricken with poverty are not really disturbed by gender imbalance; their main concern is with survival and economic security. However, the intriguing question that faced us was: why do prosperous States such as Punjab, Haryana and Himachal Pradesh have the highest incidence of female foeticide as inferred from the latest Census statistics? We took up in-depth field surveys in the three worst districts of these States to understand this phenomenon. We conducted perception surveys of doctors and panchayat members, focus groups discussions and house-to-house surveys in 9 villages in the three worst districts with the lowest child sex ratios. At the outset, we must note the following findings of a general nature:

- The force of the son complex cuts across religion, caste, socioeconomic group and place of residence, and is strong in all the three States under study.
- It is increasing with the rise of consumerism propagated by commercial TV advertising and the growing greed is reflected in higher and higher demands for dowry and the increasingly high cost of marriage.
- The spread of female foeticide has been facilitated by at least three factors, all of which are prevalent in Punjab, Haryana and Himachal Pradesh. These are (i) access to medical technology (sex determination tests and abortion); (ii) capacity to pay for the test and abortion; and (iii) a good transportation network that enables women to travel to the nearest town and also ensures that doctors can reach the villages with their equipment.

In short, female foeticide is the result of an unholy alliance between the traditional preference for sons and modern medical technology, increasing greed of doctors, rising demand for dowry that makes daughters financial burdens, the ineffectiveness of the PNDT Act and the liberal MTP Act, and the lack of any serious involvement of civil society in fighting this social menace.

Gender imbalance cannot be restored unless we make a frontal attack on **all** the players and stakeholders on the scene. It calls for concerted action involving the Government, NGOs, civil society, social reformers and individual men and women with vision.

How do we go about in this important task?

One possible way out could be the reservation of jobs both in the public and private sectors for women (say 33%). Political empowerment is not enough without economic empowerment but, in the prevailing environment in the country, when the Women's Bill could not be passed in Parliament, it is debatable whether a Bill making reservation for women in jobs will be acceptable to all political parties.

Recommendation 1

We suggest a three-sector model involving the Government, NGOs and PRIs, with technical back-up from academic experts, social activists and management experts known for their competence and integrity. Funds should be channelled to organizations that do not become victims of bureaucratic rules and regulations and are in a position to take up innovative programmes at the local level. We do not recommend adding to the vertical programmes launched by the Central Government. We plead for local-level initiatives sparked off by NGOs and individuals with vision and dedication, and run by people who have professional expertise in management. There are several success stories in India and we can draw lessons from their experience.

Recommendation 2

The Government should sanction funds to concerned and informed NGOs in the health sector to produce imaginative films (professionally produced), which would be continuously shown on TV and in cinema halls. Radio and TV (private and public) should be extensively used to change the unprogressive mindset of the people. At the same time, relentless efforts should be made to implement the PNDT Act and impose heavy punishment including cancellation of registration of erring doctors. Medical ethics must play a vital role in curbing female foeticide.

Recommendation 3

Concerted efforts must be made by governments, NGOs, social reformers, health activists and individual men and women to counteract the perverse trend of declining child sex ratio. A massive national campaign must be launched to recognise and spell out all forms of gender violence and the disastrous consequences of this demographic imbalance.

Recommendation 4

Unethical, illegal and corrupt practices (alliance between government and private doctors with assistance from ANMs, dais, paramedical staff and medical representatives) must be exposed resulting in summary punishment. All suspected cases of female foeticide and violence against women must be investigated by the State Commissions for Women and action against the guilty initiated. Female foeticide must be comprehended in the wider context of increasing violence against women.

Recommendation 5

State Supervisory Boards and Appropriate Authorities at district level should become active. Registration of ultrasound machines, no matter how strictly it is enforced, does not guarantee that pre-birth sex determination tests will not be conducted. The doctor knows how to dodge the Appropriate Authorities. What is required is vigilance at the local level. The societal mindset of demographic fundamentalism (reflected in son preference) must be addressed in creative and meaningful ways. There is a good case for empowerment of selected NGOs and health activists with a proven track record to deal with cases of female foeticide. At least on a trial basis, the Government should explore alternative strategies to introduce more effective legal machinery at the district level.

Recommendation 6

It would be very difficult to change the mindset of the large number of people who equate family planning with sterilization—a situation which is the creation of 50 years of Government propaganda and implementation of a programme of population control centred around sterilisation. We do not recommend that we give up this approach, which is largely responsible for making a real dent in the birth rate in Kerala, Tamil Nadu, Andhra Pradesh and Karnataka and, to a considerable extent, in Himachal Pradesh, Maharashtra, Gujarat, etc. Every effort must be made to improve the sterilisation programme and, in particular, the quality and extent of prior check-up and follow-up. Further, 50 years of propaganda has convinced the Indian masses about the merits of adopting a small family norm and there is enough evidence throughout the country that one son and one daughter is becoming the ideal family composition and family size. In the States under study, most people would be content with two sons and would go for sterilization, though generally speaking, one daughter is considered desirable (but never two daughters). We believe that government programmes which offer financial incentives to couples that stop after two daughters (meaning thereby, accept sterilisation) are counter-productive and a waste of money. Reproductive behaviour cannot be manipulated by such financial incentives. The new schemes on which we should work must consider special incentives for girls in the employment market (through self-help groups, etc.) or, in short, empower women in terms of their earning capacity. Then only will women be valued. This calls for a paradigm shift from the present contraceptive-oriented approach. This is a task that goes beyond the mandate of the nodal Ministry of Health and Family Welfare, and can best be earmarked for the Planning Commission. Meanwhile, the Ministry of Health and Family Welfare can continue to emphasise that the National Population Policy does not put any number such as two children, and there is no reason to opt for female foeticide to stick to this magic number of two. Our planners and policy-makers must also realise that more than the number of children, what is relevant in the eyes of the masses is the sex composition of the children and the most favoured sex composition in large parts of India is two sons and possibly one daughter. How do solve this complex puzzle? There cannot be a standard solution, given the striking demographic, socio-economic and cultural diversity of India. We recommend that the Government should opt for a decentralised model and leave the matter to the Zila Parishads, Panchayat Samitis, Panchayats and Gram Panchayats. Let this issue be sorted out at the local level.

Recommendation 7

Legislation, though important in creating an enabling environment, is not enough in changing societal norms and behaviour

patterns. Apart from legal intervention, cognitive intervention in a bigger way is a task that can best be handled by psychologists and behavioral scientists. In the modern world, the print and electronic media, and especially the film media, will be the best instruments to influence the people. This, in turn, calls for a high degree of professionalism in film making which is mostly absent in the visual material (TV ads, films, etc.) produced by government departments. The government should encourage the best film producers and seek the active help and cooperation of informed NGOs, individual scholars, and social and health activists working in this field.

Recommendation 8

Social scientists in Indian universities and research institutions should give high priority to field studies and research to understand the deep-rooted son complex in Indian society. Only then we can come out with meaningful intervention strategies that are conceptually sound. The University Grants Commission (UGC) and the Indian Council for Social Science Research (ICSSR) should likewise give the highest priority to such research while giving grants to scholars. Universities and research institutes should collaborate with outstanding NGOs in this regard; many NGOs have a better grasp of field realities than most scholars. On the other hand, most NGOs do not have adequate knowledge of the methodology of social science research. To the extent possible, such collaborative efforts should be on an institutional and not on an individual basis. Donor agencies should also encourage such collaborative efforts.

In spite of numerous national and international conferences and seminars on the girl child, as well as numerous projects and programmes funded by the government and donor agencies to help the girl child in India, there is very little evidence to suggest that the status of the girl child has improved substantially. In fact, it has worsened, as our study indicates. Our planners and policy-makers have not understood the grip of the son complex in Indian society, nor have our sociologists and behavioral scientists done enough research on this subject. In our view, the force of 'demographic fundamentalism' (reflected in the son complex) has increased all over India, but more so in the northern States.

Recommendation 9

VHAI, as a leading health NGO in India, could take up the responsibility of initiating a massive campaign throughout the country, using the print as well as the electronic media and make suitable films to generate awareness about this social evil spreading in Indian society. The nodal Ministry of Health and Family Welfare should give the fullest backing to organisations such as VHAI, without diluting their responsibility of strictly enforcing the PNDT Act through various State Ministries of Health and Family Welfare.

Recommendation 10

Dowry issues must be addressed headlong by ensuring implementation of the Dowry Act and taking stringent punitive action against violators in case of dowry deaths and dowry harassment. Help should be provided in developing a sense of security for women. Safe spaces should be created for women while travelling, working and at home, as well as shelter homes and legal aid. Opportunities must be provided for the economic empowerment of women, skill building and income generation, so that they can earn their livelihood with dignity.

Antenatal care needs to be redefined and the public must be educated about **XY**

chromosomes, and the father's role in determining the sex of the male child must be emphasised to prevent victim blaming. Efforts must be made to ensure that the mother of a girl child is treated as well as the mother of a male child. This should be **given a major thrust in the action against sex determination and female foeticide.**

Female foeticide must be stopped and efforts towards this have to be multisectoral. It must be ensured that every girl born is given her due share of love, nutrition, education and equal opportunities in life. Addressing **gender violence**, sex determination, female foeticide, female infanticide and homicide or even forced suicides by women must be addressed as a major **public health concern**.

Gender sensitization must go hand in hand with health literacy on the one hand and implementation of National Policies on the other. The latter includes the National Policy for Empowerment of Women and efforts to implement the Conventions, CEDAW, and Convention on Child Rights, which include rights of the girl child. Policies that are gender sensitive should be implemented and those that create gender, social, economic and political disparities should be resisted.

Appendix I

India's 50 worst districts with child (0-6) sex ratio (females per 1000 males) 850 or below

Rank	District	State/Union territory	Sex Ratio
1	Sangli	Maharashtra	850
2	Agra	Uttar Pradesh	849
3	Gwalior	Madhya Pradesh	849
4	Baghpat	Uttar Pradesh	847
5	Chandigarh	Chandigarh*	845
6	South West	Delhi	845
7	Rajkot	Gujarat	844
8	Una	Himachal Pradesh	839
9	Bhiwani	Haryana	838
10	Panchkula	Haryana	837
11	Kangra	Himachal Pradesh	836
12	Fatehabad	Haryana	830
13	Hisar	Haryana	830
14	Morena	Madhya Pradesh	829
15	Bhind	Madhya Pradesh	829
16	Salem	Tamil Nadu	826
17	Moga	Punjab	819
18	Firozpur	Punjab	819
19	Jind	Haryana	818
20	Sirsa	Haryana	818
21	Jammu	Jammu & Kashmir	816
22	Gandhinagar	Gujarat	816
23	Ludhiana	Punjab	814
24	Mahendragarh	Haryana	814
25	Rewari	Haryana	814
26	Ahemdabad	Gujarat	814
27	Hoshiarpur	Punjab	810
28	Nawanshahr	Punjab	810
29	Karnal	Haryana	808
30	Muktsar	Punjab	807
31	Yamunanagar	Haryana	807
32	Panipat	Haryana	807
33	Faridkot	Punjab	805
34	Jhajjar	Haryana	805
35	Mahesana	Gujarat	798
36	Jalandhar	Punjab	797
37	Rohtak	Haryana	796
38	Roopnagar	Punjab	791
39	Kaithal	Haryana	789
40	Sangrur	Punjab	784
41	Ambala	Haryana	784
42	Amritsar	Punjab	783
43	Sonipat	Haryana	783
44	Bathinda	Punjab	779
45	Mansa	Punjab	779
46	Gurdaspur	Punjab	775
47	Kapurthala	Punjab	775
48	Patiala	Punjab	770
49	Kurukshetra	Haryana	770
50	Fatehgarh Sahib	Punjab	754

Source: Census of India 2001, Provisional Population Totals, Paper 1, Series 1, Supplement District Totals, pp. 218-219,

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About VHAI

Voluntary Health Association of India (VHAI) is a non-profit, registered society formed in the year 1970. It is a federation of 24 State Voluntary Health Associations, linking together more than 4000 health care institutions and grassroots level community health programmes spread across the country.

VHAI's primary objective is to 'make health a reality for the people of India' by promoting community health, social justice and human rights related to the provision and distribution of health services in India.

VHAI tries to achieve these goals through campaigns, policy research, advocacy, need-based training, media and parliament interventions, publications and audio-visuals, dissemination of information and running of health and development projects in some difficult areas.

VHAI works for people-centred policies and their effective implementation. It sensitises the general public on important health and development issues for evolving a sustainable health movement in the country with due emphasis on its rich health and cultural heritage.

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